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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

VICTORIA

B. C.

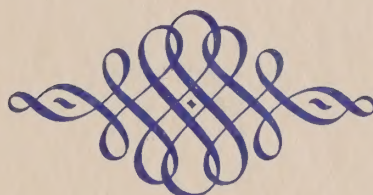
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V.28 Briefs 150 - 153  
V.28 Briefs 154 - 164



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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the Hearing  
held in Victoria, B.C.,  
19th day of February, 1962

Page

SUBMISSION OF -

ROBERT M. STRACHAN, LEADER OF THE  
OPPOSITION IN BRITISH COLUMBIA

GREATER VICTORIA METROPOLITAN BOARD OF HEALTH

CHIEF JUSTICE EMMETT M. HALL - Chairman

THE VICTORIA AND DISTRICT

DENTAL SOCIETY, N.R. DR. ALICE GIRARD

DR. DAVID M. BALTZAN

CANADIAN NATUROPATHIC ASSOCIATION

PROF. O.J. FIRESTONE

THE BRITISH COLUMBIA WOMEN'S INSTITUTE

DR. C.L. STRACHAN

DR. P. BEREGOFF-GILLOW

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. M. LAFRANCE





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INDEX

VOLUME 27

<u>SUBMISSION OF -</u>	<u>Page</u>
ROBERT M. STRACHAN, LEADER OF THE OPPOSITION IN BRITISH COLUMBIA	5813
GREATER VICTORIA METROPOLITAN BOARD OF HEALTH	5898
THE VICTORIA AND DISTRICT DENTAL SOCIETY	5919
CANADIAN NATUROPATHIC ASSOCIATION	5932
THE BRITISH COLUMBIA WOMEN'S INSTITUTE	5949
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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

CHIEF JUSTICE EMMETT M. FULTON

MR. DAVID M. BAILEY

MR. H. W. HARRIS

DR. ARTHUR E. VAN DER

DR. PETER E. JOHNSON

DIRECTOR OF RESEARCH



Victoria, British Columbia  
Monday, February 19, 1962

THE CHAIRMAN: Ladies and gentlemen, we will now come to order and the Commission is here to receive submissions from all who might wish to be heard, and in particular, of course, to receive submissions of those who have indicated they would have submissions to make,

This is the eighth province we have been in, and we have found in all seven provinces that we have concluded our Hearings in a widespread interest in the subject matters upon which we were asked to investigate and make a report by the Government of Canada. Judging from the number of those who wish to make submissions in British Columbia the pattern appears to be the same here as in the other provinces, only by far the greater number, 38 in all, have indicated they will be making representations in Vancouver when we move to Vancouver to start hearings there tomorrow morning.

Is there anyone present representing or to speak for the Government of the Province of British Columbia or the Dept. of Health or one of the government departments?

The first submission that we will receive this morning, of which we have had prior notice, is a brief by Mr. Robert M. Strachan, leader of the opposition in the British Columbia Legislature.

Mrs. Strachan.

BRIEF OF ROBERT M. STRACHAN, LEADER OF THE  
OPPOSITION IN BRITISH COLUMBIA





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in the British Columbia Legislature.



Strachan

5814

APPEARANCES:

ROBERT M. STRACHAN

---

---EXHIBIT NO. 144: Brief of Robert M. Strachan, Leader  
of the Opposition in B.C.

MR. STRACHAN: Thank you very much, Mr.  
Chairman.

Let me first of all express my regret that  
there was no one here from the Government of the Province  
of British Columbia to welcome this most important  
Commission in their first Hearing in our great province.

THE CHAIRMAN: That wouldn't be best com-  
pletely accurate. I have a few minutes with Mr. Bennett.  
He said we were most welcome in the Province of British  
Columbia.

MR. STRACHAN: I will add my welcome to Mr.  
Bennett's. In essence as the Leader of the Opposition in  
this particular province I represent the 62 percent of  
the people who support the Government but don't vote for  
them. That may seem a little hard to understand, but  
that is the situation in British Columbia politics.  
However, it was primarily because of the importance of  
this discussion, of these Hearings that I felt the Govern-  
ment should have been the first to place their thinking  
on the record as a background to all of the succeeding  
briefs. I think before I start with the summary of sub-  
missions which I sent to you in Ottawa I would like to  
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Strachan

5815

expressed officially on a number of occasions. This will be an indication to you that there is no major difference in policy between the Opposition and the Government of the Province of British Columbia. I would like to start by reading two pages of a speech made by the present Minister of Health, Mr. Martin while speaking to the Legislature in February, 1956. I am quoting the Honourable Eric Martin at this time when he was speaking on health care and I quote:

Speech by Eric Martin - Feb. 1956 - in Legislature

#### HEALTH CARE PLAN

Following a preliminary planning and development meetings during 1955, a Federal-Provincial conference on Health insurance was convened in Ottawa on January 23, 1956, and continued through January 26th. Each province was called upon to outline its views and describe the programme of health services presently in effect in the province.

As an introduction to the B.C. Programme, I presented the following summary of principles advocated by the Province of British Columbia for the further development of a health programme:

1. B.C. endorses the principle of an all-inclusive National Health Programme.
2. B.C. recommends that the following services be included in a National Health Programme:

(i) Hospital care for both acute and chronic conditions, including laboratory and X-ray





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Speech by Eric Martin - Feb. 1966 - in Legislature

### HEALTH CARE PLAN

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Strachan

5816

diagnostic service to in-patients.

(ii) Laboratory and X-ray diagnostic service  
to out-patients.

(iii) Home nursing service.

(iv) Medical care service.

(v) Dental care. (For children only during  
early stages.)

(vi) Certain drugs, prescriptions, artificial  
limbs and appliances.

3. The cost of the programme should be borne  
equally by the Federal and Provincial Governments.

4. The Federal contribution to each province  
should be based on the actual cost experienced in  
the Province, and not on Canadian average costs or  
Canadian average utilization rates.

NOTE: B.C.'s health care costs are higher due to  
of the Federal Provincial  
at least two factors:

(i) Many health services in this Province are  
already more highly developed and more ex-  
tensively utilized by the people.

(ii) B.C. has a higher proportion of aged  
persons, which persons require more health care.

B.C. believes that the Federal Government  
should recognize all such factors and should share  
equally in the higher costs.

5. The National Health Programme should be de-  
signed in such a way as to permit step-by-step  
implementation. It is neither necessary nor  
logical that all phases of the programme should be  
inaugurated simultaneously.





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(ii) B.C. has a higher proportion of aged people.

B.C. believes that the Federal Government should recognize all such factors and should share equally in the higher costs.

5. The National Health Programme should be designed in such a way as to permit step-by-step implementation. It is neither necessary nor logical that all phases of the programme should be



Strachan

5817

6. Each province should be free to determine the order and the manner by which each phase of their health programme is to be introduced.

7. Each province should be free to determine the manner in which it shall finance its own share of the health funds.

8. B.C. believes that there is a distinct advantage to the flexibility and the administrative freedom advocated for the provinces in the foregoing proposals. It is reasonable to expect that ultimately a more efficient health programme can be evolved if experience can be gained through a number of different administrative approaches.

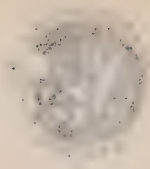
That was in 1956.

In a brief presented to the plenary session of the Federal-Provincial Conference at Ottawa on July 25th, 1960 submitted by the Honourable, the Premier, W. A. C. Bennett, he made this submission, this is referring to the health programme:

#### HEALTH PROGRAMME

In the 1945 Green Book Proposals, the National Government proposed removal of the crippling financial burden of medical services on the Canadian family by a Federal-Provincial health insurance plan financed by national and provincial taxation.

In my statement to the Federal-Provincial Conference of 1955, I said: -- here he is quoting himself --



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In my statement to the Federal-Provincial Conference of 1955, I said: -- here he is quoting himself





Strachan

5818

"British Columbia recommends that this Conference agree in principle upon the desirability of a health programme adaptable to the requirements of the individual provinces; that such a plan make provision for medical, hospital, dental and pharmaceutical services; and that the Federal Government share equally in the cost of such a health programme to the extent that they have been or may be adopted by a province to meet its special requirements."

Our view was reiterated at the Federal-Provincial Conference of 1957:

"British Columbia has endorsed the principle of a national health programme and has indicated its willingness to take part in such a programme immediately."

The Hospital Insurance and Diagnostic Services Act has since provided joint Federal-Provincial financing of hospital services for most Canadians.

British Columbia recommends to this Conference that steps be taken to implement a full medical programme, to be shared on equal basis by the Provincial and Federal Governments.

This, as I say, was July 25th, 1960, so at the Government level I think it is fairly obvious that the Government is in favour of an over-all health programme. I will now read the summary of my submission on behalf of the Opposition Party.

#### SUMMARY OF SUBMISSIONS

1. Access to the finest medical care available is a





Strachan

5819

basic human right which must be made available to every person in Canada regardless of his means.

2. The medical profession should not have either the moral or legal right to obstruct or defeat a national or provincial medical care plan.

3. Necessary legislation must spell out clearly the fact that the patient's right to health services is an enforceable legal right and must ensure that no person eligible for medical care can be refused such care by the medical profession.

If you want to add a footnote there you might add, legitimate, for legitimate illness.

4. A medical care plan for Canada should be compulsory, as is Hospital Insurance in British Columbia, and should cover every citizen for all hospital care including psychiatric and tuberculosis care, complete medical, dental and optical care, X-ray and laboratory services, necessary drugs, artificial limbs and appliances and ambulance services.

5. The patient must have free choice of doctor.

6. No third party such as a private insurance or ambulance company should be allowed to profit from a health scheme.

7. Drugs must be supplied at cost with drug manufacture and wholesale distribution under public ownership.

8. The medical profession must be treated fairly, must be given complete MEDICAL freedom, and must receive adequate compensation.







Strachan

5820

9. Deterrent fees should not be considered.

Patients must not be deterred from consulting a doctor in the early stages of disease. If any deterrents are deemed necessary, they should be limited to token payments for drugs and other supplies.

10. There must be no subsidies paid to existing plans such as M.S.A. These plans should be absorbed into the national or provincial scheme.

11. Administration of health plans should be left to provincial governments with the Federal Government sharing costs.

12. Provincial administration must be undertaken by a body responsible to the legislature.

13. Government assistance for the education and training of doctors and for research facilities must be an integral part of any health plan.

14. Canada cannot afford the economic waste caused by sickness which amounted to 20,228,000 man days of employment in 1960.

15. A health scheme should be financed on similar lines to the present Hospital Insurance, and nationally should be financed as part of an over-all social security scheme. An approximate estimate for a medical care plan for British Columbia would be \$40 million, but this would not be \$40 million of new money as the public is paying almost this amount for the present inadequate coverage. A medical care plan for British Columbia should be put into effect immediately pending the creation of a national plan.



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9. Deficiency fees should not be considered.

Patients must not be deterred from consulting a doctor in the early stages of disease. If any deterrents are deemed necessary, they should be limited to token payments for drugs and other services.

10. There must be no subsidies paid to existing plans such as N.S.A. These plans should be absorbed into the national or provincial system.

11. Administration of health plans should be left to provincial governments with the federal government

12. Provincial administration must be undertaken by a body responsible to the legislature.

13. Government responsibility for the education and training of doctors and other health personnel must be an integral part of any health plan.

14. Canada cannot afford the expense of waste caused by sickness which amounted to \$2,500,000 per year of employment in 1950.

15. A health scheme should be financed on a basis lines to the present Hospital Insurance, and National Insurance should be financed as part of an overall social security scheme. An approximate estimate for a national scheme for British Columbia would be \$70 million, but this would not be \$50 million of new money as the public is paying almost this amount for the present insurance coverage. A medical care plan for British Columbia should be put into effect immediately pending the creation of a national plan.





Strachan

5821

16. The medical profession has created a political action fund with the specific purpose of defeating a plan for medical care to cover everyone in Canada. Although trade unions in British Columbia are prevented from creating similar funds by the Labour Relations Act, the doctors are free to make levies on the members of their Medical Association for such purposes and have done so. In actual fact this amounts to a forced political levy on a patient's bill.

17. Existing prepaid plans have failed to provide comprehensive coverage for every citizen. They only cover an estimated 54% of Canadians.

This 54% is a sensible figure because of the fact, dependent on the economic condition, many people who are now covered by such private schemes such as M.S.A., when they get in the unemployment brackets are not covered by any scheme at all. You will find that figure varies from year to year depending on the conditions.

THE CHAIRMAN: This is for all ten provinces?

MR. STRACHAN: I would think it would be.

THE CHAIRMAN: 54%

MR. STRACHAN: Yes.

THE CHAIRMAN: Have you the figure for British Columbia?

MR. STRACHAN: I think later on in my brief I use the figure of 65% for British Columbia, later on in the full presentation.





Strachan.

5822

These plans are expensive and frequently exclude from their benefits vital services such as "home and office visits in case of illness." The plans are, in the main, controlled by doctors who are the prime financial beneficiaries from the plans.

18. In British Columbia unemployed employable persons on social allowance receive no medical coverage; neither do those who are medically unemployable unless they remain on social allowance in excess of three months.

Incidentally, you will notice in my main brief I expected that the Province would be submitting a brief, because, naturally, the Government have access to many figures which we, in the Opposition do not have. In the Annual Report of the Welfare Branch recently tabled in the House the number of unemployed employable was given for two centres in the Province. We find in the City of Prince George it is 1,047 people, and in the Fraser Valley, 1606. These are only two of the communities in the Province. As unemployed employables they have no medical coverage at all.

Thus a section of our population who cannot afford medical care are denied it unless they care to beg for it from the medical profession. These regulations were made by joint agreement between the medical profession and the government. Another group, those receiving Unemployment Insurance, are in a similar plight.

19. We have compulsory superannuation plans, compulsory hospital insurance, compulsory income tax, compulsory sales tax, compulsory education, and we are





These plans are... their benefits... in case of... connected by...

18. In... on social... to those who... remain to...

... I expect... a body, because... to carry... In the... added in the... was given... the city of... the... construction... they have...

... of the... efforts... may... let... progression and...

19. We have...

... and we are...



Strachan

5823

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3 compelled in B.C. to take telephone services from one  
4 company; therefore, the argument that compulsory health  
5 insurance is wrong has no validity.

6 20. The argument that a minute percentage of patients  
7 will abuse a health scheme is no valid or logical reason  
8 to deny care to the balance of the population and in  
9 any event evidence in this brief shows that abuse is  
10 just as likely to come from the medical profession as  
11 from the patient.

12 21. The fee-for-service system of payment to general  
13 practitioners is not the only way in which the medical  
14 profession could be remunerated for its services. It  
15 does say they prefer to work straight up, so it is  
16 certainly one method to be considered, but there is  
17 much support within the profession for a capitation  
18 system. Patients receiving treatment under this capi-  
19 tation system in British Columbia and in other countries  
20 do not receive an inferior type of medical service.

21 22. A government scheme would not interfere in any  
22 way with what is popularly known as the doctor-patient  
23 relationship. In fact, the absence of financial barriers  
24 will improve this relationship.

25 23. The British National Health Service has been the  
26 most successful and beneficial to the health of the  
27 patient, and the nation as a whole, in the world.

28 24. The Australian National Health Service is only  
29 a second best, uneconomic system by comparison to Britain  
30 and provides less service to the patient. Such a system  
should not be considered in Canada.

31 25. The prime purpose of a health scheme for Canada  
32 must be to help the patient.







Strachan

5824

26. A medical care plan should be devised to meet the conditions in Canada and the needs of Canadians and should not be a mere copy of plans existing in other countries.

Thank you, Mr. Chairman.

THE CHAIRMAN: Thank you very much, Mr.

Strachan.

THE CHAIRMAN: Mr. Strachan, we, amongst the members of the Commission, may have a few questions to put to you. At your option, you may remain seated, if you wish; although other persons like yourselves sometimes say they prefer to speak standing up, so it is at your option.

I am interested in one observation you make at page 3 of the brief itself, Mr. Strachan, and to follow along with what you have said, you say this:

"In view of the above facts, I think it is essential that any legislation spell out quite clearly the fact that medical services are not only the patient's basic moral right but also an enforceable legal right."

MR. STRACHAN: Do you want me to enlarge on that?

THE CHAIRMAN: I would like you to enlarge on that, and perhaps not so much enlarge on it but if you can tell me by what legislative process such a right could be enforced? Because, I mean, it seems to be inherent in your brief that there is not much use having a right unless you can have access to it and get benefit from it.



A medical case plan should be devised to meet the conditions in Canada and the needs of Canadians and should not be a mere copy of plans existing in other

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I am interested in one observation you make at page 3 of the brief itself, Mr. Stinchcombe, and to follow along with what you have said, you say that:

"In view of the above facts, I think it is essential that any legislation which is put forward clearly the fact that medical services are not only the property of the state but also an enforceable legal right."

THE CHAIRMAN: I would like you to enlarge

on that, and perhaps not so much enlarge on it but if you can tell me by what legislative process such a right could be enforced? Because, I mean, it seems to be inherent in your brief that there is not much use having a right unless you can have access to it and get benefit

from it.



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3 MR. STRACHAN: Well, this thinking arises  
4 out of the history in the Province of British Columbia,  
5 where in the 1930s after a great deal of research, Royal  
6 Commission Hearings, legislation was passed in this  
7 province to set up a comprehensive medical care plan.  
8 That legislation was passed by the legislature of that  
9 day. It still stands on the statute books of this pro-  
vince, but to this day we have not got such a scheme.

10 THE CHAIRMAN: These are the remarks which  
11 preceded your statement, you see.

12 MR. STRACHAN: Yes, yes. I point that out  
13 that even after a provincial plebiscite had shown that the  
14 majority of the people in British Columbia wanted a  
15 health plan, and the Royal Commission had recommended  
16 such a plan, the doctors refused to practise within the  
17 Act.

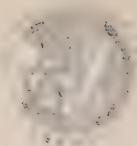
18 THE CHAIRMAN: My question, perhaps, comes  
19 to this. How do you enforce the right to medical service?  
20 I mean, I know that we can and have conscripted people  
21 to defend the country, but how do you conscript the  
22 medical profession to give service to A, B, C and D?

23 Well, it is a matter of the  
24 fact -- I mean most citizens are naturally law-abiding.  
25 If a law is passed, they naturally want to remain within  
26 that law.

27 THE CHAIRMAN: Because there is a sanction  
28 for its enforcement. If, by some misfortune, we violate  
29 the law there is some way to keep us on the road.

30 MR. STRACHAN: In other words, some of these  
would have to be laid down. What those penalties should





MR. STRACHAN: Well, this is a matter

out of the history in the Province of British Columbia, where in the 1930s after a great deal of research, Royal

Commission Hearings, legislation was passed in this

province to set up a comprehensive medical care plan.

That legislation was passed by the legislature of that

day. It still stands on the statute books of this pro-

vince, but to this day we have not got such a scheme.

THE CHAIRMAN: There are the reasons which

preceded your statement, you see.

MR. STRACHAN: Yes, yes. I point that out

that even after a provincial committee had shown that the

majority of the people in British Columbia wanted a

health plan, and the Royal Commission had recommended

such a plan, the doctors refused to practice within the

Act.

THE CHAIRMAN: My question, perhaps, comes

to this. How do you enforce the right to medical service?

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3 be, I am not going to suggest.

4 THE CHAIRMAN: You suggest that if a doctor  
5 were called to attend a patient and did not, that there  
6 would be a penalty imposed on him for not doing so?

7 MR. STRACHAN: I am not thinking so much  
8 of the individual doctor. I am thinking as if there is  
9 a concerted agreement by the doctors.

10 THE CHAIRMAN: Then, are you going to put  
11 a penalty against them all? The machinery of this in-  
12 trigues me, Mr. Strachan, to tell you the truth, and I  
13 would like to know if you have followed it through to  
14 the point of being able to say how you would enforce this  
15 legal right to medical services?

16 MR. STRACHAN: Well, I think the Commission,  
17 if it is going to recommend legislation, would be serv-  
18 ing the interests of the people, if they spelled it out.

19 THE CHAIRMAN: We are looking to men in  
20 public positions, such as you occupy, to give us assist-  
21 ance.

22 MR. STRACHAN: I read you the section of the  
23 Act passed by the legislature.

24 THE CHAIRMAN: The one in 1933?

25 MR. STRACHAN: Yes, it was Chapter 171,  
26 R.S.B.C., 1948, and it says that every person who in  
27 violation of any provision of this act does any act which  
28 he is prohibited from doing or refuses or neglects to  
29 perform or observe any duty or obligation imposed on him  
30 is guilty of an offense against this Act and is liable  
on summary conviction to a fine of not less than \$10.  
and not more than \$500.



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were called to attend a patient and did not, that there

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on summary conviction to a fine of not less than \$100

and not more than \$500.





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3 THE CHAIRMAN: Yes, I can follow that, not  
4 having the provisions of the statute before me, but is  
5 there anything in there that says that a medical person  
6 shall on being called do so and so?

7 There are many phases in that Act: You are  
8 supposed to make reports, send in statements, do this  
9 that and the other thing, but does it say any place they  
10 must render the service? Is that one of the provisions?

11 MR. STRACHAN: I do not think it says so  
12 in the Act.

13 THE CHAIRMAN: Therefore, that penalty clause  
14 only applies where the Act sets up an obligation, and  
15 you have a breach of that obligation and then the penalty  
16 clause may be invoked.

17 What does it say about the duties of the  
18 medical profession in the Act?

19 MR. STRACHAN: Section 27, sir. In ad-  
20 dition to other penalties prescribed by or under this  
21 Act, the Commission may penalize any person including any  
22 physician or pharmacist and the manager of any hospital  
23 or laboratory who fails to provide services according  
24 to the standards prescribed by this Commission and who  
25 willfully violates any provision of this act or of the  
26 regulations by debarring him either permanently or for a  
27 limited period from all rights of serving or providing  
28 benefits for insured persons under this Act.

29 COMMISSIONER McCUTCHEON: That means that the  
30 penalty is to get rid of the medical profession?

MR. STRACHAN: Well, this would depend on  
the medical profession.



THE CHAIRMAN: Now, I can follow that, not

having the provisions of the statute before me, but is there anything in there that says that a medical person

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MR. STRACHAN: Section 14, etc. In 194-

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3 THE CHAIRMAN: Is there any requirement, and  
4 this may be facetious, Mr. Strachan, that they should  
5 remain within the province?

6 MR. STRACHAN: I do not know. No, there is no  
7 requirement that they remain within the province.

8 THE CHAIRMAN: You see, it is in the working  
9 out of what may be an easily stated principle that dif-  
10 ficulties can arise, and that is why I put the question  
11 quite seriously as to how far you have been able to  
12 think the thing through to the end in practice to  
13 achieve the best of physicians' services in the Province  
14 of British Columbia.

15 MR. STRACHAN: Well, I think it is an accepted  
16 norm in our society that no one group is ever allowed  
17 to defeat the purposes of that society, and I think that  
18 we must find some way of preventing any one group from  
19 defeating the purposes of society.

20 THE CHAIRMAN: Does your thinking go this  
21 far, that you would deny to the physician the right to  
22 withdraw his services?

23 MR. STRACHAN: You cannot force any indivi-  
24 dual to do that which he does not want to do. If a  
25 physician utilizes the facilities provided in this  
26 province for his training; and, remember, that most of  
27 these facilities are provided from public funds, from  
28 the taxpayer's dollar, and remembering the high calling  
29 to which our physician gives allegiance, I cannot see  
30 that we would want to do this on a reasonable basis,  
providing that there was a reasonable scheme drawn up.

I think it should be impressed on the medical





THE CHAIRMAN: Is there any requirement, and this may be tacitly, Mr. Strachan, that they should remain within the province?

MR. STRACHAN: I do not know. No, there is no requirement that they remain within the province.

THE CHAIRMAN: You see, it is in the working out of what may be an easily stated principle that difficulties can arise, and that is why I put the question quite seriously as to how far you have been able to think the thing through to the end in relation to achieve the best of physicians' services in the Province of British Columbia.

MR. STRACHAN: Well, I think it is an accepted norm in our society that in one group is very difficult to defeat the purposes of that society, and I think that we must find some way of preventing any one group from defeating the purposes of society.

THE CHAIRMAN: Does your mind go to this far, that you would deny to the physician the right to withdraw his services?

MR. STRACHAN: You cannot force any individual to do that which he does not want to do. It is physician utilizes the facilities provided in this province for his training; and, remember, that most of these facilities are provided from public funds, from the taxpayer's dollar, and remembering the high calling to which our physician gives allegiance, I cannot see that we would want to do this on a reasonable basis, providing that there was a reasonable scheme drawn up. I think it should be interested on the medical



Strachan

5829

profession the very widespread evidence that society is demanding a comprehensive medical care plan, and if they remember their high calling they will co-operate with it.

However, I am of the opinion that many of the doctors in the province and in Canada generally are perhaps not aware of the fact that much of the thinking on this does not stem from an actual knowledge of the situation or the requirements of Canada.

I have the feeling that the medical profession in British Columbia and in Canada generally has been subjected to pressures from the medical association of another country. And the medical profession forget, I feel, that this is Canada and that the people of Canada have a different concept of social services than is the case in the United States, and if the medical profession realize this, I am sure we would have no problem.

THE CHAIRMAN: Well, we cannot purport to enter into any form of debate on ideas that some may possess and some may deny, but what we are concerned with is trying to find some system which will work and which will give the best and the highest standard of service. MR. STRACHAN: Right. Agreed.

THE CHAIRMAN: And if the insistence on compulsion is going to be the factor that may cause a breakdown in service, do you think we should try to search out first a system in which compulsion does not necessarily have to be a part?

MR. STRACHAN: If you can find a system by which -- a system that has the least compulsion, I think,

profession the very widespread evidence that society is demanding a comprehensive medical care plan, and if they remember their high calling they will co-operate with it.

However, I am of the opinion that many of

the doctors in the province and in Canada generally are perhaps not aware of the fact that much of the thinking on this does not stem from an actual knowledge of the situation or the requirements of Canada.

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THE CHAIRMAN: Well, we cannot permit to

enter into any form of debate on ideas that are not possess and some may deny, but what we are concerned with is trying to find some system which will work and

which will give the best and the most efficient of service.

MR. STURGES: Right. Agreed.

THE CHAIRMAN: And in the meantime we are

question is going to be the factor that may cause a

breakdown in service, do you think we should try to

search out first a system in which competition does not

necessarily have to be a part?

MR. STURGES: If you can find a system by

which a system that is not competitive can be





Strachan

5830

is the one we are looking for, but we have to impress on those involved in this that it is the requirement of the mass of the people -- if we get to express a pious hope and limit it to the expression of this pious hope that everyone will be very nice and co-operate, then I think we will find that history will repeat itself and there will be no co-operation.

THE CHAIRMAN: Well, Mr. Strachan, is it suggested seriously in British Columbia today that anyone has been without medical services even though they were not able to pay for them?

MR. STRACHAN: The doctors tell us regularly that they never refuse to treat anyone, but I think there is a psychological economic barrier.

THE CHAIRMAN: I mean you have access to many sources of information in the province?

MR. STRACHAN: Yes.

THE CHAIRMAN: I mean, do you, from your experience and from the reliable information that you would act upon, know of any situation where anyone is without medical service really for want of money?

MR. STRACHAN: I know of people who refused to go to the doctor because it is going to incur cost.

THE CHAIRMAN: We hear of that; that is said, yes.

MR. STRACHAN: Yes, and I had a case just recently of an elderly lady who was developing cataracts in her eyes. She was outside of the medical benefits care category, and she just refused to go to the doctor because it meant incurring a doctor's bill. This was a



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Strachan

5831

case just recently.

Doctors do not refuse to treat them, let me make that clear. Had she gone to the doctor, the doctor would have treated her, but because of her inherent pride and her feeling she just refused to go. This is the barrier that must be removed.

THE CHAIRMAN: Now, Mr. Strachan, I want to come to a statement you make on page 12 at about line 16, in that paragraph.

MR. STRACHAN: Yes.

THE CHAIRMAN: If this occurred, that is if your party was elected in British Columbia, then we would finance a provincial scheme partly with money that is now received from the Federal Government for hospital insurance. This is the expression now that I want to draw particularly to your attention, and I quote:

"And which is not being used for this purpose by the present provincial government."

Now, are you suggesting there that part of the money which Ottawa provides for the hospital insurance is not being properly used? And, if so, we would be very interested in hearing from you in that respect.

MR. STRACHAN: Well, if you examine the estimates of the Province of British Columbia, you will find allocated from the general revenue of the province a sum that is approximately two-fifths of the 5 percent sales tax which is gathered in the Province of British Columbia. When this legislation was introduced, and I believe it was 1954 or 1955, increasing the sales tax





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Had she gone to the doctor, the doctor would have treated her, but because of her inherent pride and her feeling she just refused to go. This is the

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THE CHAIRMAN: Now, Mr. Stansbury, I want to

come to a statement you made on page 15 and about page

THE CHAIRMAN: If this occurred, that is

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Now, are you suggesting that that part of the money which Ontario provides for the hospital insurance is not being properly used? And, if so, we would be very interested in hearing from you in that

MR. STANSBURY: Well, if you examine the

estimates of the Province of British Columbia, you will find allocated from the general revenue of the province a sum that is approximately two-fifths of the amount which is paid now in the Province of Ontario. When this legislation was introduced, and I believe it was 1954 or 1955, increasing the sales tax



Strachan

5832

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3 in this province from a 3 percent to a 5 percent, the  
4 premium system of hospital insurance was abolished, and  
5 it was very definite that this two-fifths of the 5 per-  
6 cent sales tax was for hospital insurance purposes.

7 THE CHAIRMAN: Now, that is provincial money.

8 MR. STRACHAN: Yes. I am explaining the  
9 working of the estimates. So they allocated this figure,  
10 and then alongside it is shown a Federal contribution  
11 which in this province is somewhere between 45 percent  
12 and 50 percent of the total.

13 You add these two figures together and this  
14 is monies that have been allocated or collected for  
15 hospital insurance purposes. Hospital operating costs,  
16 in essence, because that is what the premium is. We  
17 find that year after year the sum of these two is not  
18 spent for hospital operating costs in the Province of  
19 British Columbia.

20 THE CHAIRMAN: What I want to come to is  
21 this, and I want to put it as clearly to you as I can  
22 without going in side lanes or chasing any side issues.  
23 What you say here, and I read it categorically, I  
24 thought..." and partly that money that is now received  
25 from Federal Government for hospital insurance and which  
26 is not being used for this purpose by the present  
27 Provincial Government." That, to me, means that the  
28 Provincial Government gets X dollars from the Dominion  
29 Government for hospital insurance from which it only  
30 spends X minus Y, and therefore pockets some of the  
Dominion Insurance money for other purposes. Do you  
say that is happening?

in this province from a 3 percent to a 5 percent, the premium system of hospital insurance was abolished, and it was very definite that this two-fifths of the 5 percent sales tax was for hospital insurance purposes.

MR. STACHAN: Yes. I am explaining the working of the estimates. As they allocated this figure and then alongside it is shown a federal contribution which in this province is somewhere between 45 percent and 50 percent of the total.

You add these two figures together and this is monies that have been allocated or collected for hospital insurance purposes. Hospital operating costs, in essence, because that is what the premium is, we find that year after year the sum of these two is not spent for hospital operating costs in the province of

THE CHAIRMAN: What I want to come to is this, and I want to put it as clearly as you can without going in side lanes or causing any side issues. What you say here, and I read it categorically, I thought... and partly that money that is now received from Federal Government for hospital insurance and which is not being used for this purpose by the present Provincial Government. That, to me, means that the Provincial Government gets Y dollars from the Dominion Government for hospital insurance from which it only spends X minus Y, and therefore pockets some of the Dominion insurance money for other purposes. Do you say that is happening?





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3 MR. STRACHAN: Yes, I say that is happening,  
4 yes.

5 THE CHAIRMAN: In what way?

6 MR. STRACHAN: As I have just explained, you  
7 take the two figures collected in the province. Once  
8 you create an omelet out of the Federal egg and the sales  
9 tax egg, it is difficult to get them back into separate  
10 eggs. But there is created a sum of money, and this sum  
11 of money is not spent for hospital insurance in the  
Province of British Columbia.

12 THE CHAIRMAN: You mean they do not spend  
13 all they get out of the 2 percent?

14 MR. STRACHAN: The 2 percent, and the Federal  
15 Government contribution. They are then lumped together,  
16 they are mixed up, and year after year this sum is not  
17 spent for hospital insurance in the Province of British  
Columbia.

18 THE CHAIRMAN: If that is your explanation,  
19 then that does not give me the concern that I get when  
20 I read your article. I thought we were going to come on  
21 somebody who was pocketing the Dominion Government money.

22 MR. STRACHAN: Someone might say that all the  
23 money collected from the sales tax is not being used for  
24 hospital insurance, despite the fact this essentially was  
why it was increased.

25 COMMISSIONER McCUTCHEON: You said essentially?  
26 There is nothing in the law that they must earmark two-  
27 fifths of the sales tax for hospital insurance?

28 MR. STRACHAN: The law says from time to time  
29 from the general revenue certain sums will be allocated.  
30

MR. STRACHAN: Yes, I say that is happening.

THE CHAIRMAN: In what way?

MR. STRACHAN: As I have just explained, you

take the two figures collected in the province. Once you create an omelet out of the Federal egg and the sales tax egg, it is difficult to get them back into separate eggs. But there is created a sum of money, and this sum of money is not spent for hospital insurance in the Province of British Columbia.

THE CHAIRMAN: You mean they do not spend

all they get out of the 2 percent?

MR. STRACHAN: The 2 percent, and the Federal

Government contribution. They are then added together, they are mixed up, and year after year this sum is not spent for hospital insurance in the Province of British Columbia.

THE CHAIRMAN: Is that as your explanation,

then that does not give me the concern that I get when I read your article. I thought we were going to come on somebody who was pocketing the Dominion Government money.

MR. STRACHAN: Someone might say that all the

money collected from the sales tax is not being used for hospital insurance, besides the fact this essentially was why it was increased.

COMMISSIONER HENDERSON: You said essentially

There is nothing in the law that they must earmark two-

fifths of the sales tax for hospital insurance.

MR. STRACHAN: The law says from time to time

from the general revenue certain sums will be allocated.



Strachan

5834

I am thinking of what was said when the legislation was introduced to the House and what the people of this province were told.

THE CHAIRMAN: The money which the province gets from the Dominion Government by the formula, that is arrived at each year having regard to the Dominion average and the Provincial usage and that kind of thing. That is based on actual operating expenses in the hospital; a percentage of actual operating expenses?

MR. STRACHAN: I believe so.

THE CHAIRMAN: And that will come to X dollars. And what that X dollars does not cover, then, must come from Provincial funds?

MR. STRACHAN: Yes.

THE CHAIRMAN: I mean, we get a fixed amount from Ottawa and must make up the residue from provincial funds? Is that not right?

MR. STRACHAN: As I understand it.

THE CHAIRMAN: Including administration costs?

MR. STRACHAN: I am looking at the over-all figures created by two sums of money.

THE CHAIRMAN: If you had said that I would have understood it as you have explained it now. There is another item that may require some explanation. On page 17, you are dealing there with type of coverage under M.S.A. and you refer to, this is in paragraph B about line 14:

"The type of coverage varies widely and is far from comprehensive. For example, M.S.I.,



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THE CHAIRMAN: The money which the province gets from the Dominion Government by the formula, that is arrived at each year having regard to the Dominion average and the Provincial usage and that kind of thing. That is based on actual operating expenses in the hospital; a percentage of actual operating expenses?

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THE CHAIRMAN: And that will come to a collision. And what that collision does not cover, then, must come from Provincial funds?

MR. STACHAN: Yes.

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THE CHAIRMAN: If you had said that I would have understood it as you have explained it now, there is another item that may require some explanation. On page 14, you are dealing there with type of coverage under M.S.A. and you refer to, this is in paragraph 5 about line 14:

"The type of coverage varies widely and is far from comprehensive. For example, M.S.I.,



Strachan

5835

a scheme sponsored by Medical Services Association, a non-profit organization in British Columbia, while charging \$84. per year for a family, lists the following among numerous services: NOT COVERED: - 'Home and office visits in case of illness.'

MR. STRACHAN: Yes.

THE CHAIRMAN: Are you suggesting there that there is only one type of contract of M.S.I.?

MR. STRACHAN: No, there are several types of contracts.

THE CHAIRMAN: Are you suggesting that home and office visits are excluded in all contracts?

MR. STRACHAN: No.

THE CHAIRMAN: You are suggesting it is being excluded in the \$84 a year contract?

MR. STRACHAN: Yes.

THE CHAIRMAN: I would like to discuss that with you for a moment because it is an interesting suggestion. M.S.I. have furnished us with copies of their contracts -- have you had access to the briefs being filed by M.S.A.?

MR. STRACHAN: No.

THE CHAIRMAN: Well, I have here the certificate for individual medical services plan and it is the one, you are talking about, I think, where it has in block letters "Home or office visits in cases of illness excluded."

MR. STRACHAN: Yes, I have not seen that document.

THE CHAIRMAN: I was wondering if you had



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THE CHAIRMAN: You are suggesting it is being

excluded in the M.S.I. contract?

MR. STRACHAN: Yes.

THE CHAIRMAN: I would like to discuss that

with you for a moment because it is an interesting and  
 question. M.S.I. have furnished us with copies of their  
 contracts -- have you had access to the contracts being

filed by M.S.I.?

THE CHAIRMAN: Well, I have been the centre-

locate for individual medical services plan and it is  
 the one you are talking about. I think, where it has its  
 place before some of office visits in cases of illness

excluded."

MR. STRACHAN: Yes, I have not seen that

document.

THE CHAIRMAN: I was wondering if you had





Strachan

5836

because that is a \$2. a month policy, \$24 a year and not an \$84 policy.

MR. STRACHAN: You will find I am quoting from the advertisements placed in the paper, it was placed in the press of this province.

THE CHAIRMAN: Well, it would be your reading of the advertisement, I would take it?

MR. STRACHAN: I think you will find that M.S.I. has single coverage and groups up to nine, I think it is, and there is a variance there too between individual single persons with M.S.I. coverage and a group.

THE CHAIRMAN: This policy which does exclude home or office visits in case of illness is a policy for surgical, maternity and medical care in hospital and necessary care at home or in the doctor's office for disabilities occasioned by accidental means and cutting procedures so it was not intended to cover illness at home.

MR. STRACHAN: So it bears out my statement, it is not a comprehensive scheme, it does not cover widely enough.

THE CHAIRMAN: Except you said that was what they were charging, \$84 a year for?

MR. STRACHAN: That is per family, if you add the sums of money required you will find that it adds up to \$84.

THE CHAIRMAN: That will remain to be --

MR. STRACHAN: The advertisement as it appeared in the paper gave one person, two persons and



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Strachan

5837

a family, three groups. Now, what it would cost in each and in the group that do not have the coverage it showed \$84.

THE CHAIRMAN: Are you able to give the figure for the broadest coverage of M.S.I.?

MR. STRACHAN: All I have is the advertisement that appeared in the press.

THE CHAIRMAN: Are you able to give the figure for the broadest coverage?

MR. STRACHAN: No, I have not got it.

THE CHAIRMAN: You are not suggesting all the policies are this exclusive?

MR. STRACHAN: No.

THE CHAIRMAN: You just found it in this one?

MR. STRACHAN: I am giving it as an instance of what it is costing people for this limited coverage. It bears out my initial statement that this type of coverage varies widely and is far from comprehensive. Then I say:

"For example, M.S.I., a scheme sponsored by Medical Services Association, a non-profit organization in British Columbia, while charging \$84 per year for a family, lists the following among numerous services not covered:"

THE CHAIRMAN: I am suggesting to you if that is the contract you are suggesting to us supporting your statement that it does not appear to support the statement. That is all I am suggesting to you, the \$84 basis.

MR. STRACHAN: They had better get someone





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3 else to write their advertisements.

4 THE CHAIRMAN: If you want to file the news-  
5 paper advertisements we would be glad to have them.

6 MR. STRACHAN: I would like to read that.  
7 If you add it up I suggest it comes to \$84 for the  
8 limited coverage.

9 THE CHAIRMAN: Perhaps you had better read  
10 it. We would be happy to let you have it or the secre-  
11 tary would be able to give you the exhibit from the  
12 submission.

13 MR. STRACHAN: Could you give me the section  
14 of that contract that tells you how many people the  
\$2.00 a month covers?

15 THE CHAIRMAN: The contract itself does not  
16 set up any premium basis.

17 MR. STRACHAN: It does not. Well, where do  
18 you get the figure of \$2.00 a month?

19 THE CHAIRMAN: That is in the brief sub-  
mitted by M.S.I.

20 MR. STRACHAN: Does it say \$2.00 per month  
21 per person?

22 THE CHAIRMAN: This is a single person.

23 MR. STRACHAN: That is it, I was quoting a  
24 family and I said \$84. per year for a family -- \$2.00  
a month.

25 THE CHAIRMAN: There is no provision for the  
26 family in the prospectus.

27 MR. STRACHAN: In my brief I mentioned  
28 desirability of coverage for a family. \$2.00 a month is  
29 \$24. a year for a person, and 4 times that is \$96. and  
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you put the figure of \$2.00 a month?

THE CHAIRMAN: That is in the printed and-

MR. STRACHAN: Does it say \$2.00 per month?

THE CHAIRMAN: This is a single person.

MR. STRACHAN: That is it, I was quoting a

family and I said \$84 per year for a family -- \$2.00

a month.

THE CHAIRMAN: There is no provision for the

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MR. STRACHAN: In my brief I mentioned

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Strachan

5839

you get a reduction down to \$84.

THE CHAIRMAN: Dr. Baltzan, you had some questions?

COMMISSIONER BALTZAN: I go on the premise that the public record must show (a) the nature of our enquiry and (b) that the objective nature of the information is obtained on that basis. I would like for one minute to turn to the last question on page IV of your summary, paragraph 26:

"A medical care plan should be devised to meet the conditions in Canada and the needs of Canadians and should not be a mere copy of plans existing in other countries."

Correct me if my impression is not correct but I have the feeling that most people have the same desire and most individuals have the same confidence in the wisdom of its citizens. Would you be willing to add "Copyists of foreign plans stay out."?

MR. STRACHAN: Willing to add what?

COMMISSIONER BALTZAN: Copyists of other plans stay out?

MR. STRACHAN: Well, no.

COMMISSIONER BALTZAN: Not so far?

MR. STRACHAN: No, I am indicating how it happens, I think you are familiar with this, I find many of the arguments pro and con based on some particular system in Britain or some particular system in Australia or some particular system elsewhere and what we would evolve would not necessarily be any one of them.

THE CHAIRMAN: You do not want to import a



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THE CHAIRMAN: Dr. Baitan, you had some

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COMMISSIONER BAITAN: I go on the premise

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MR. STACHAN: Willing to add what?

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3 system holus bolus?

4 MR. STRACHAN: No.

5 COMMISSIONER STRACHAN: Yet you say it is a  
6 perfect system, the best in the world so why not copy it?

7 MR. STRACHAN: For that country; I do not  
8 say we should copy it. ~~the way~~.

9 COMMISSIONER STRACHAN: You say it is the  
10 best in the world.

11 MR. STRACHAN: So they say. I want the  
12 coverage to be the best to meet Canadian needs.

13 COMMISSIONER BALTZAN: In other words, like  
14 many of us you have very great confidence in our own  
15 Canadian concept of consciousness? ~~the way~~

16 MR. STRACHAN: Right.

17 COMMISSIONER BALTZAN: Now, to come back to  
18 the first page of the summary:

19 "Access to the finest medical care available  
20 is a basic human right which must be made available  
21 to every person in Canada regardless of his means."

22 The point I want to raise there is, do you  
23 take in three premises, access and availability is one,  
24 finest medical care is two and supplemented by the basic  
25 human rights which is due to all Canadians. Now, access  
26 and availability takes in a good number of things:  
27 access by prevention of barriers, access by providing  
28 facilities, access by providing transportation. Right?  
29 Are these within the field of what we will call, say,  
30 the medical team work or is that a sociological problem?

MR. STRACHAN: Well, the access means, as I  
put it, the absence of barriers and in essence the





system holds points?

MR. STRACHAN: No.

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MR. STRACHAN: Well, the access means, as I

understand it, the access to doctors and in essence the



Strachan

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proposal is that you remove any barriers, mental or any other type that may exist between the citizens and adequate health care.

COMMISSIONER BALTZAN: In other words, it depends on a number of factors and there is no one in particular that is in the way.

MR. STRACHAN: The fact it would vary from individual, from area to area. We cannot say. The only reason we don't have comprehensive medical care is inability of anyone to pay, we cannot say it is due to a doctor situation because there are a number of factors.

COMMISSIONER BALTZAN: That is true. With regard to the finest medical care you would then conceive there must be provision for the finest kind of medical schools, the finest kind of research, the finest kind of financing. I have read some of them in the body of your brief, and I want to reiterate and get the impressions of and the whole concept and under what proposition that is before this body to submit to the Government.

MR. STRACHAN: I agree to it as you have expressed it.

COMMISSIONER BALTZAN: Then there are basic human rights and the chairman has already discussed that and he is much more competent to discuss that than I. That basic human right is sometimes God-given which is beyond means of control. I am here referring to the question of the congenital diseases, the hereditary diseases, the mutations which come on which are irreversible so neither Government nor man can control

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Strachan

5842

these needs. You say it is a basic human right and yet there are some things beyond man's control.

MR. STRACHAN: Yes, that is true that for most of us we look on certain illnesses as a manifestation of some celestial force. However, if we accept that then we also inject into the medical profession another manifestation of that celestial force.

COMMISSIONER BALTZAN: I would like to hear it.

MR. STRACHAN: Because here are men and women of great dedication and just as this celestial force has visited a sickness on an individual so he has given another individual a certain capacity, a certain mental force to help offset that. If we accept one premise we must accept the other.

COMMISSIONER BALTZAN: And one premise that you mention that is not accepted in the same terms of reference is that even in spite of that people are born with congenital hearts, these same people will go ahead and correct them.

MR. STRACHAN: That is right. Are they going against --

COMMISSIONER BALTZAN: No, it is not for me to say you are for or against, I am only for getting all the information in order to set my thinking straight and you are helping me.

MR. STRACHAN: I have to determine first of all, are you inferring that because someone is born with a heart problem someone is going against a religious belief if they think through medical practise or



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MR. TROTTMAN: Yes, that is true that for

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Dr. Trotman because you say you women of great devotion and just to this celestial force has visited a sickness on the individual as he has given another individual a certain capacity, a certain mental force to help offset that. If we accept one premise we must accept the other.

COMMISSIONER: And one premise that you mention that is not accepted in the same realm of reference as that even in spite of that people are born with abnormal hearts, these same people will be afraid and accept them.

COMMISSIONER:

COMMISSIONER: No, it is not for to say you are for or against, I am only for getting all the information in order to get the thinking straight and you are helping me.

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Strachan 5843

operation they can correct that. Is that what you were trying to say?

COMMISSIONER BALTZAN: A little bit broader. I am trying to say when people are faced with this thing it should be a basic right to hold there are some things beyond man's capacity to control. That is why I am asking and so people will understand and be reminded of these things.

MR. STRACHAN: That is right.

COMMISSIONER BALTZAN: That is why I am asking.

MR. STRACHAN: That merely reiterates what the chairman said at the opening of these Hearings, I think in Newfoundland, where the chairman said:

"Future powers be developed taking into account increasingly by the government that opportunity for good health is a right possessed by all and need become available in one form or another to all citizens of Canada."

COMMISSIONER BALTZAN: Exactly, and I am the first one to support the chairman's statement.

MR. STRACHAN: So do I.

THE CHAIRMAN: We are one happy family here this morning.

COMMISSIONER BALTZAN: It is then a question of opportunity that must be provided?

MR. STRACHAN: Quite.

COMMISSIONER BALTZAN: So that the individual can take it or leave it?

MR. STRACHAN: Right.





Proceedings

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COMMISSIONER BATTAN: So that the individ-

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Strachan

5844

COMMISSIONER BALTZAN: He may even abuse it by over-eating, by over-drinking, by taking drugs.

MR. STRACHAN: That is right.

COMMISSIONER BALTZAN: By moonlighting.

MR. STRACHAN: By all night sittings of the legislature.

COMMISSIONER BALTZAN: And reading a big brief.

MR. STRACHAN: The preparation of those big briefs.

COMMISSIONER BALTZAN: You have a little advantage, you have two or three months. We have only one night for some of these. Just to continue on a little bit, if you will allow. You are being very generous. No. 2, the medical profession should not have either the moral or legal right to obstruct or defeat a national provincial medical care plan. I agree with you. It is practically incontrovertible. What you say in 26 is a broad statement about the medical care plan. You don't say there -- have you got 26? You don't say whether it should be an unplanned plan. When you say a medical plan, you don't say anything for or against it. You don't qualify. Perhaps you will now. You don't say under this medical care plan whether it is a non-profit prepaid plan. You don't say whether the growing subsidized plans are any good or not or would serve the purpose. You don't say whether they should be completely government administered or government controlled, compulsory plans -- what have you in mind?

THE CHAIRMAN: What page are you talking about?



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Strachan

5845

COMMISSIONER BALTZAN: I am at Roman IV, the last paragraph, 26 and referring it back, I am actually on this part of paragraph 2. Which one of these plans have you in mind?

MR. STRACHAN: Even in the summary I think I have answered all the questions you have just asked, sir. I say it should be a medical care, compulsory, I say it should cover every citizen and none of the existing plans cover every citizen. It should be for all hospital care and so on. Then later on I say the administration of a health plan should be left to the Provincial Government with the Federal Government sharing costs, paragraph 10. There must be no subsidies paid to existing plans such as M.S.A.

COMMISSIONER BALTZAN: The summary leaves it a little bit open. I am glad you have said this.

MR. STRACHAN: I don't believe in any unplanned planning.

COMMISSIONER BALTZAN: You claim the profession should not have either the moral or legal right to obstruct or defeat a national or provincial medical care plan. Is it not more correct, sir, to say that they resent and try to defeat a government controlled plan. Do you think, and I am asking you, is the impression abroad that they are opposed to a provincial wide plan, a national wide plan, or is the main objection to the fact it might be, say, a government-controlled plan?

MR. S. TRACHAN: The way you say government-controlled, you make it sound even nasty.



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COMMISSIONER BALTAN: You claim

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MR. STRACHAN: The way you say government-

controlled, you make it sound even nastier.



Strachan

5846

COMMISSIONER BALTZAN: Some people think so.

MR. STRACHAN: Some people think so. This depends on what government you have, by the way. This may be their objection. I think the objection is unfounded. It would seem to me that unless we have such a comprehensive government-sponsored over-all medical care plan we are left in our present position with the hodge-podge and patchwork, in my opinion it isn't, doesn't answer the needs of Canada.

COMMISSIONER BALIZAN: Correct, and I follow you. One must read into the history. There was a time that certain lay people, citizens, plus the medical profession took steps in that direction, they have for at least 21 years in this province.

MR. STRACHAN: Right.

COMMISSIONER BALTZAN: One could even go so far as to say they have been going forward, and not backward.

MR. STRACHAN: Yes, I could say that.

COMMISSIONER BALTZAN: They want to expand that as far as possible, given time, and 21 years has not, apparently, fulfilled their wishes if I read into their wishes, correctly. They have attempted.

MR. STRACHAN: Oh yes. They have attempted, and you have to give them full credit for the job that has been done. No one is attempting to take that away from them. However, this experience, I think it is obvious -- it is impossible for such a scheme to give an over-all comprehensive medical care that I feel is now a requirement of the community.



29 new a requirement of the community.

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24 at least 21 years in this province.

23 profession took steps in that direction, they have for  
22 that certain lay people, citizens, plus the medical

21 you. One must read into the history. There was a time

20 COMMISSIONER BALTAN: Correct, and I follow

19 doesn't answer the needs of Canada.

18 hodge-podge and patchwork, in my opinion it isn't.

17 case plan we are left in our present position of a

16 a comprehensive government-sponsored over-all medical

15 founded. It would seem to me that unless we have such

14 may be their objection. I think the objection is un-

13 depends on what government you have, by the way. This

12 MR. STRACHAN: Some people think so. This

11 COMMISSIONER BALTAN: Some people think so.



Strachan

5847

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3 COMMISSIONER BALTZAN: Yes, sir, and I fol-  
4 low you. You read from your Premier's message or letter  
5 or reference where he said it is also what he wants,  
6 and then he says he wants it done step by step. Have  
7 you a better way than step by step? Have you a way to  
8 go holus-bolus in this that you can make work?

9 MR. STRACHAN: I accept the step-by-step  
10 attitude. We have been taking it step by step, and now  
11 is the time for the next step, for the next step.

12 COMMISSIONER BALTZAN: You haven't exactly  
13 a time limit that you can go ahead and do that within  
14 the next month or the next year?

15 MR. STRACHAN: No.

16 COMMISSIONER BALTZAN: And so have they got  
17 in their record they are making step by step progress,  
18 but maybe not fast enough?

19 MR. STRACHAN: Yes, that is right. I mean  
20 we attach importance to our own 50 or 60 or 70 years in  
21 this vale of tears. We think it is the most important  
22 part of history. We would like to see some of these  
23 things done in our time.

24 COMMISSIONER BALTZAN: Then I think we are  
25 all old enough to say what has happened has happened in  
26 our time. We want to live a little bit longer.

27 MR. STRACHAN: Yes.

28 COMMISSIONER BALTZAN: No, 6, sir, on the  
29 first page: no third party such a private insurance or  
30 ambulance company should be allowed to profit from a  
health scheme. Why just those two?

MR. STRACHAN: These were just examples.



COMMISSIONER BALDWIN: Yes, sir, and I fol-

low you. You read from your brother's message or letter  
or reference where he said it is also what he wants,  
and then he says he wants it done step by step. Have  
you a better way than step by step? Have you a way to  
go hold-on-point in that that you can make work?

MR. STRACHAN: I accept the step-by-step

attitude. We have been taking it step by step, and now  
is the time for the next step, for the next step.

COMMISSIONER BALDWIN: You haven't exactly

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Strachan

5848

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3 COMMISSIONER BALTZAN: What would you say  
4 about X-ray manufacturers?

5 MR. STRACHAN: I say no third party such as  
6 private insurance or ambulance companies should be  
7 allowed.

8 COMMISSIONER BALTZAN: You don't say anybody.  
9 That is too bad because you spoiled my question. Roman  
10 II, your summary 11 and 12. I keep them together be-  
11 cause they both mean the same thing. Administration of  
12 health plans should be left to provincial governments  
and to the federal government....

13 MR. STRACHAN: Yes -- no, they don't mean  
14 the same thing. Paragraph 12 takes you a step further.  
15 Paragraph 11 says the administration of health plans  
16 should be left to provincial governments with the federal  
17 government sharing costs. If you leave administration  
18 of health plans to the provincial government that  
19 government might then be tempted to leave the admini-  
20 stration to the M.S.A. and the M.S.I. and all the other  
21 groups. The next paragraph says the provincial admini-  
22 stration must be undertaken by a body responsible to  
23 the legislature. In other words a government agency of  
24 some kind, not a group such as we now have. Paragraph  
12 takes it a step further.

25 COMMISSIONER BALTZAN: And you believe, and  
26 I ask, that they are the most knowing and most under-  
27 standing and most competent -- the government can do  
28 that without taking in the participation of the people  
29 who have joined in the administration of some of these  
30 plans.

COMMISSIONER BALTIAN: What would you say

about X-ray radiologists?

MR. STACHAN: I say no third party such as

private insurance or ambulance companies should be

allowed.

COMMISSIONER BALTIAN: You don't say anything.

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MR. STACHAN: Yes -- no, they don't mean

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Strachan

5849

MR. STRACHAN: I don't say that, provincial administration must be undertaken by a body responsible to the legislature. This body responsible to the legislature must be a Health Insurance Commission composed of 21 doctors and 2 laymen.

COMMISSIONER BALTZAN: Would it work the other way?

MR. STRACHAN: I wouldn't suggest that. You suggested that. It would be a Commission, not necessarily a government department, but this body, whatever it may be, must be responsible to the legislature.

COMMISSIONER BALTZAN: Would it work in another way, with governments having the appointing and controlling?

MR. STRACHAN: The governments would appoint the Commissioner or whatever it happened to be. I am not going into the details.

COMMISSIONER BALTZAN: Would you say in the hands of another government than the one yourself would like to have?

MR. STRACHAN: I am making the suggestion.

We have many government commissions now and nobody consults me when they appoint the Commissioners to the Workmen's Compensation Board or the Power Commission or the Directors of the B.C. Electric. No one consults me, quite normally. This doesn't mean I am against the B.C. Electric, the Power Commission or the Workmen's Compensation Board.

COMMISSIONER BALTZAN: Paragraph 16. You



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COMMISSIONER BALTAN: Paragraph 16. You



Strachan

5850

say the medical profession has created a political action fund. I have been given this information, that the medical profession claims they created an anti-political action fund to keep politicians out of medicine.

MR. STRACHAN: Well, if the medical profession wants to embark on a discussion of semantics with me I will take them on any time. That is in essence what they say. It is a semantic juggle, because if we are going to have a comprehensive medical care plan I think it is clearly demonstrated that the politicians are the people who pass legislation. That is what they are elected to do, to pass legislation for the benefit of all the people and assist generally. That is a general statement. Any time a group sets out and takes the stand it is an anti-political fund, it is done for political purposes, to either elect or defeat politicians depending on what these politicians think, so it is a political fund. It is semantic nonsense when they say they have created an anti-political fund.

COMMISSIONER BALTZAN: I am glad to hear you think like this, I wouldn't want to be on a debating team with you. Whether one side is right or the other, could one be generous enough to say that the medical profession has not officially become affiliated with one political party in that they now -- I am trying to get a point of view.

THE CHAIRMAN: Dr. Baltzan, Mr. Strachan, we are here as a Commission to get certain information and views. Mr. Strachan is entitled to put forward his views. He has put them forward. It is not the purpose



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Strachan

5851

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2  
3 of this Commission to defend anybody or to get into  
4 political arguments. I think the question you are now  
5 putting is one that should not be pursued further.

6 COMMISSIONER BALTZAN: I accept that ruling,  
7 sir. I don't intend, as I said at the beginning, I  
8 want to understand all sides and that is how I direct  
9 my questions, sir. There are statements here that we,  
10 the Commission, are entitled to know, and Mr. Strachan  
11 has been very fair, sir, and I hope, if I am given time  
12 to finish that you will find that I have been also very  
fair and interested in what you have to say.

13 You make a statement, and allow me, Mr.  
14 Chairman, that the British National Health Service has  
15 been most successful and beneficial to the health of  
16 the patient and the nation as a whole, in the world.  
17 That is Roman IV, paragraph 23.

18 MR. STRACHAN: Yes.

19 COMMISSIONER BALTZAN: I would be indeed  
20 very happy to have any -- anyone say that he has found  
21 perfection. I am sure you have gone into the history.  
22 Professor John Jewkes, of Oxford University in his  
23 Genesis of British National Health Services says, and  
24 I am not going to read the whole works, the average  
25 American now has more medical services than the average  
26 Britain and the gap between the two frontiers -- I use  
that word -- between the two countries has been widened.  
That is another point of view. That is J.E. Jewkes.

27 MR. STRACHAN: I said the most successful.  
28 There was nothing final. There is a matter of degree.  
29 It is not the ultimate. I don't suggest it is the  
30

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MR. STRACHAN: Yes.

COMMISSIONER BALTMAN: I would be indeed very happy to have any -- anyone say that he has found perfection. I am sure you have gone into the history.

Professor John Lanks, of Oxford University in his lecture of British National Health Service says, and I am not going to read the whole works, the average American now has more medical services than the average Briton and the gap between the two frontiers -- I use that word -- between the two countries has been widened.

That is another point of view. That is U.S. Lanks.

MR. STRACHAN: I said the last one was not.

There was nothing there. There is a matter of opinion.

It is not the ultimate. I don't suggest it is the



Strachan

5852

ultimate. I use the word most. This indicates a matter of degree in relation to others in our own country.

COMMISSIONER BALTZAN: I understand that, sir.

MR. STRACHAN: That is my information.

COMMISSIONER BALTZAN: Yes, and it is very respectful. There are other points of view. That is what I want to say.

MR. STRACHAN: Oh, yes.

COMMISSIONER BALTZAN: This isn't final. I have others here, but time is running out.

MR. STRACHAN: I have it somewhere here, I think in Appendix A.

COMMISSIONER BALTZAN: I read that, Dr. Bain. I could read on further, I would like to refer you to the Genesis of British National Health by Professor John Jewkes of Oxford University and his wife.

MR. STRACHAN: I agree. Almost all of the schemes have some limitation. They have people that abuse them. I read the book, Honour by Physician, which was a crystallization of the experience of one medical man with this small number of cases, I don't know how many patients -- somewhere between 2,000 and 3,000 patients. In this, in essence he is talking about 6 people. It is a crystallization of the abuse of the system. You have a book that is given to six people. How about the 2,994 who were benefiting from the scheme and using it without abuse and getting better medical care than they had before. I agree people will abuse it.



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COMMISSIONER BAILLIE: I understand that.

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COMMISSIONER BAILLIE: Yes, and it is very  
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MR. STRACHAN: I have it somewhere here, I  
think in Appendix A.

COMMISSIONER BAILLIE: I read that, Mr. Bailie.  
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the basis of British National Health by Professor  
John Lewis of Oxford University and his wife.

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and using it without abuse and getting better medical  
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Strachan

5853

That is no reason for rejecting a good idea.

COMMISSIONER STRACHAN: That is what medical people sometimes refer to as a medical report on a series of cases of one.

Paragraph No. 12, and I am through shortly, Mr. Chairman. A brief glance into the history shows us that society has always established standards which must be met by those wishing to qualify as doctors or as dentists. What society, do you mean society as a whole? That is page 3, no. 12, Mr. Strachan.

MR. STRACHAN: What was the question again?

COMMISSIONER BALTZAN: My question is what society do you mean, do you mean society as a whole?

MR. STRACHAN: Society as a whole.

COMMISSIONER BALTZAN: You say that they have provided the standards or established the standards?

MR. STRACHAN: Society has established the standards which must be met.

COMMISSIONER BALTZAN: Which doctors or the medical teams must meet?

MR. STRACHAN: Yes.

COMMISSIONER BALTZAN: Reading into the same history to which you referred has society actually been the mover in the direction for better standards and better services than those people who were engaged in promoting and developing the standards?

MR. STRACHAN: I think history shows that the people get what they desire. To go back to where we were earlier, politicians make decisions. The politicians of this province decided to have the

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That is page 3, not 12, Mr. Strachan.  
MR. STRACHAN: What was the question again?  
COMMISSIONER BATTAN: The question is what  
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MR. STRACHAN: Society as a whole.  
COMMISSIONER BATTAN: You say that they  
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Strachan

5854

University in this province. The politicians on behalf of the people decided to put a medical faculty into the University because they felt there weren't sufficient doctors. They decided to make sure there were doctors of sufficient training. The University of British Columbia is a government-sponsored institution.

Society the controller of people. The people through the government have now decided we are going to build a University hospital which the doctors themselves tell us will improve the standards of medical practice in the Province.

COMMISSIONER BALTZAN: Thank you. You anticipated my next question. It is not always society but segments of society that move politicians or move governments.

THE CHAIRMAN: Well, maybe, but I think we have heard enough about politicians.

COMMISSIONER BALTZAN: I will not use the word again, but I want to establish this --

THE CHAIRMAN: I am not suggesting that Mr. Strachan has improperly used it, either. I am merely saying that the questions and observations are not related to our terms of reference now.

MR. STRACHAN: I am trying to confine my answers to suit the questions.

THE CHAIRMAN: You must do that, Mr. Strachan.

COMMISSIONER BALTZAN: I am referring to the history, and I am trying to really interpret history in its broad sense. You have used it here. I have

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COMMISSIONER BATTAN: Thank you, you have answered my next question. It is not always society but segments of society that have politicians or have, however.

THE CHAIRMAN: Well, maybe, but I think we have heard enough about politicians.

COMMISSIONER BATTAN: I will not see the

word again, but I want to establish this --

THE CHAIRMAN: I am not sure that that is. Strahan has already used it, either. I am saying that the questions and observations are not related to one form of reference.

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Strachan

5855

asked you first, about the society and you were good enough to say what I thought you would say, that society as a whole, but I want to go on and ask you about many crusades have been taken on by the part of people, organizations, societies, medical, nursing, etc., and sometimes they have failed; they have failed for 100 years, say, in vaccination. They have failed in other respects; they have failed to influence the people in connection with fluoridation universally. The standards of practice were and are and have always been promoted or lead by those who have had a lot of experience in legislation by legislatures in nursing, by nurses like Florence Nightingale, and in advances of medicine by scientists and by doctors practising in medicine. Am I right?

MR. STRACHAN: Right.

COMMISSIONER BALTZAN: You agree with me there?

MR. STRACHAN: Oh, yes.

COMMISSIONER BALTZAN: So they are not always the followers, but quite often the leaders.

I think, sir, and I hope you consider I was fair and that I was trying to get information so that we could understand one another, and you have been very fair and I thank you.

MR. STRACHAN: Thank you.

COMMISSIONER VAN WART: I have just one question to ask. In your summary on page 4, paragraph 24, and in your brief on page 5, paragraph 5, you suggest that the remuneration for services shall be either







Strachan

5856

fee for service or by capitation.

Do I infer from that that you exclude the principle of remuneration by salary?

MR. STRACHAN: I do not exclude it, but I simply listed the two alternatives that in my opinion are the best. I do not exclude salaries at all.

COMMISSIONER VAN WART: And where you mention fee for service first, do you give it priority over capitation?

MR. STRACHAN: Not necessarily.

COMMISSIONER VAN WART: That is all. Thank you.

COMMISSIONER STRACHAN: Just for clarification, on page 6, paragraph 10:

"Government assistance for the education and training of doctors and for research facilities must be an integral part of any health plan."

MR. STRACHAN: Yes.

COMMISSIONER STRACHAN: I am sure you will agree that in the world of today, the term doctor is an extremely broad one, and yet in the health field in its broadest sense it is a very limited one, or, a limited term.

What I would like to know is whether you refer to the training of physicians only, or whether you refer to the training of all health personnel including physicians, dentists, physio-therapists, nurses and likewise?

MR. STRACHAN: Well, I would answer that by saying it includes the provision of the high quality



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are the best. I do not exclude salaries at all.

COMMISSIONER VAN VANT: And where you mention

use for service first, do you give it priority over

consultation?

MR. STRACHAN: Not necessarily.

COMMISSIONER VAN VANT: That is all. Thank

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Strachan

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3 staff required in every field of medical service:  
4 doctors, dentists --

5 COMMISSIONER STRACHAN: Medical or health  
6 services?

7 MR. STRACHAN: Medical or health services, yes.

8 THE CHAIRMAN: But, I mean, do you equate  
9 medical and health as one unit, or is health broader  
10 than medical? I think that is what Dr. Strachan means.

11 COMMISSIONER STRACHAN: I said medical or  
12 health, yes.

13 MR. STRACHAN: Well, there is a relationship  
14 between the two, and I would not say -- I can only re-  
15 peat the statement I made that I am advocating govern-  
16 ment assistance to provide the staff required to cover  
17 the whole field of medical and/or health service.

18 THE CHAIRMAN: Dr. Strachan wants to know if  
19 you want to support dentists as well?

20 DR. STRACHAN: Oh, yes, yes, definitely.

21 COMMISSIONER STRACHAN: The way you have  
22 put it here you are limiting it to those with a doctor's  
23 degree in health services.

24 MR. STRACHAN: Well, most dentists have a  
25 doctor's degree.

26 COMMISSIONER STRACHAN: Yes, quite, but I  
27 am not thinking of the two in particular. I am think-  
28 ing of all personnel who enter into health services be-  
29 cause we have suggestions from the groups which I have  
30 already mentioned, plus a larger number not mentioned.

MR. STRACHAN: I think I mentioned somewhere  
in my brief the need for a dental school.

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ment assistance to provide the staff required to cover

the whole field of medical and health services.

THE CHAIRMAN: Dr. Stachan, what do you think

you want to put at dentists in health?

MR. STACHAN: Oh, yes, dental health.

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degree in health services.

MR. STACHAN: Well, most dentists have a

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Strachan

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4 COMMISSIONER STRACHAN: I am not talking  
5 about that; I am not trying to confine it to dentists.

6 MR. STRACHAN: I want the broadest inter-  
7 pretation -- the broadest possible interpretation put  
8 on that.

9 COMMISSIONER STRACHAN: You recognize the  
10 fact that there are many in the health field who do not  
11 hold a doctor's degree?

12 MR. STRACHAN: Yes.

13 COMMISSIONER STRACHAN: So, you have actually  
14 made a very limiting statement.

15 MR. STRACHAN: This was not my intention.  
16 There are people referred to as doctors in the University  
17 of British Columbia who are not medical practitioners  
18 but engaged in pretty important scientific research  
19 that will affect the health of the nation. All of these  
20 people, too.

21 COMMISSIONER STRACHAN: That is what I said  
22 in the first place. It was a very, very broad term  
23 today.

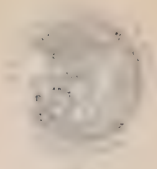
24 MR. STRACHAN: Yes, yes.

25 COMMISSIONER STRACHAN: Thank you.

26 COMMISSIONER FIRESTONE: You have put for-  
27 ward a very forthright brief. You have said you are  
28 in favour of a comprehensive or all-inclusive health  
29 service programme for the Province of British Columbia,  
30 and you have suggested some Federal participation in  
such a programme.

Some of the observations you have made are  
hypothetical in nature, for fairly obvious reasons, but





COMMISSIONER STRACHAN: I am not talking

about that; I am not trying to confine it to dentists.

MR. STRACHAN: I want the broadest inter-

pretation -- the broadest possible interpretation but

on that.

COMMISSIONER STRACHAN: I do recognize the

fact that there are many in the health field who do not

hold a doctor's degree.

MR. STRACHAN: Yes.

So, you have actually

made a very limiting statement.

MR. STRACHAN: This was not my intention.

There are people referred to as doctors in the university

of British Columbia who are not medical practitioners

but engaged in pretty important scientific research

that will affect the health of the nation. All of these

people, too.

COMMISSIONER STRACHAN: That is what I said

in the first place. It was a very, very broad term

today.

Yes, yes.

COMMISSIONER THORNTON: You have not for-

ward a very forthright reply. You have said you are

in favour of a comprehensive all-inclusive health

service program for the Province of British Columbia,

and you have suggested some federal participation in

such a program.

Some of the observations you have made are

hypothetical in nature, for solely obvious reasons, but



Strachan

5859

I hope it will be satisfactory to you if some of the questions would deal with hypothetical situations.

Is that acceptable to you, sir?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: May I turn, first, to Paragraph 5 of the substance of your brief, on page 1?

MR. STRACHAN: Yes.

COMMISSIONER STRACHAN: You say, sir:

"If, as I expect, this Commission recommends a comprehensive health plan, then I am of the opinion that it should recommend legislation to ensure that person eligible for medical care can be refused such care by the medical profession."

Is this recommendation conditional on the Commission recommending a comprehensive health plan, or do you hold this view irrespective of the Commission's recommendations?

MR. STRACHAN: Well, the statement was made on the premise that is included in the statement, where I say: "If, as I expect, this Commissions recommends a comprehensive health plan."

That is the premise on which I make the suggestion. Then, I am of the opinion that it should also recommend legislation to ensure that no one eligible for medical care can be refused such care by the medical profession.

COMMISSIONER FIRESTONE: You are quite right. The record says what it says, but I am asking you a question. The question is, are you satisfied solely to make this recommendation as a conditional recommendation,



I hope it will be satisfactory to you if some of the questions would deal with hypothetical situations. Is that acceptable to you, sir?

Paragraph 5 of the substance of your brief, on page 12. MR. STRACHAN: Yes.

COMMISSIONER STRACHAN: Yes sir, sir. "If, as I explain, this Commission recommends a comprehensive health plan, then I am of the opinion that it should recommend legislation to ensure that person eligible for medical care can be released such care by the medical profession."

Is this recommendation contained in the Commission recommending a comprehensive health plan, or do you hold this view irrespective of the Commission's recommendation?

MR. STRACHAN: Well, the statement was made on the premise that as in fact in the statement, where I say, "If, as I report, this Commission recommends a comprehensive health plan."

That is the premise on which I make the suggestion. Then, I am of the opinion that it should also recommend legislation to ensure that no one eligible for medical care can be released such care by the medical profession.

The second says what it says, but I am asking you a question. The question is, are you satisfied solely by





Strachan

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3 or would you go to the extent of saying that it is an  
4 unconditional recommendation as far as you are concerned?

5 MR. STRACHAN: No, I would not, for the primary  
6 purpose of this, I think I outlined earlier was to im-  
7 press upon the doctors themselves the importance of such  
8 a comprehensive plan and to indicate that society would  
9 frown on any boycotting of the Government proposed plan  
10 by the doctors. This is the basis of it.

11 The reason I would not extend it, I would not  
12 put forth such a proposal if no plan was suggested by  
13 the Commission. It takes me back to the point where I  
14 told you of the lady who simply refused to go to the  
15 doctor because she couldn't afford it. This makes it im-  
16 possible for the doctors, then, to fulfill the intent of  
17 it.

18 COMMISSIONER FIRESTONE: But, as I understand  
19 it, you have recommended in this report that if there is  
20 no federal plan forthcoming the province should proceed  
21 with a plan independently. Am I correct?

22 MR. STRACHAN: Right.

23 COMMISSIONER FIRESTONE: If the province were  
24 to proceed with such a plan independently, would you still  
25 want this provision enacted?

26 MR. STRACHAN: Yes, I would want this pro-  
27 vision enacted.

28 COMMISSIONER FIRESTONE: Therefore, the answer  
29 to my question is that this is an unconditional recom-  
30 mendation as far as the Province of British Columbia is  
concerned?

MR. STRACHAN: Yes, providing there is an





Strachan

5861

over-all health plan going to be implemented, and I think such a plan must include -- as this original Act did.

COMMISSIONER FIRESTONE: When you speak of an over-all health plan with this qualification, are you referring to Canada or to British Columbia?

MR. STRACHAN: To both. Whether we have the Provincial over-all health plan, I think this might be part of the legislation.

COMMISSIONER FIRESTONE: Can we stop right at this point?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: I understand your broader point. If there is a Federal plan, obviously the Commission can make recommendations. That part I have understood.

I am just trying to establish the relationship of this particular recommendation in paragraph 5 and the reconciliation of that recommendation with a statement found subsequently in the report that you are in favour of introducing a Provincial programme if no Federal programme is forthcoming, or if this is delayed -- as you know, sometimes these things take time -- and I understand then that you would feel this recommendation should be implemented in conjunction with implementation of a provincial programme?

MR. STRACHAN: Right.

COMMISSIONER FIRESTONE: But, in this respect it is not a conditional recommendation?

MR. STRACHAN: No.

COMMISSIONER FIRESTONE: Thank you.





over-all health plan going to be implemented, and I think such a plan must include -- as this original Act did.

COMMISSIONER FINKSTON: When you speak of an over-all health plan with this qualification, are you referring to Canada or to British Columbia?

MR. STRACHAN: To both. Whether we have the

provincial over-all health plan, I think this might be part of the legislation.

COMMISSIONER FINKSTON: Can we stop right at this point?

MR. STRACHAN: Yes.

broader point. If there is a Federal plan, obviously the Commission can make recommendations. That part I have understood.

I am just trying to establish the relationship of this particular recommendation in paragraph 2 and the reconciliation of that recommendation with a statement found subsequently in the report that you are in favour of introducing a provincial programme if no Federal programme is forthcoming, or if this is delayed -- as you know, sometimes these things take time -- and I understand that you would feel this recommendation should be implemented in conjunction with implementation of a provincial programme?

it is not a conditional recommendation?

MR. STRACHAN: No.



Strachan

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Now, you say -- and I come back to the second half of that recommendation -- that you recommend legislation to ensure, and you have dealt with this subject really in part in answering the chairman's question. I am now concerned not with provincial legislation which was discussed earlier, but I am interested in the matter of how this relates to the role of the Federal Government.

What did you have in mind that the Commission could recommend to the Federal Government as to changes in Federal Legislation that would take account of the point which you have in mind here?

MR. STRACHAN: Would you repeat your question, please?

COMMISSIONER FIRESTONE: Paragraph 5 suggests that the Commission should also recommend, and I take it recommend to the Federal Government ---

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Then, I quote:

"To ensure that no person eligible for medical care can be refused such care by the medical profession."

My question is what legislative changes do you have in mind at the Federal level, as distinct from the Provincial level?

This Commission, as you know, is concerned in advising the Federal Government.

MR. STRACHAN: This does not really require changes in Federal legislation, but as a part of the health scheme implemented by the Federal Government for participation by the provinces, the Federal Government



Now, you say -- and I come back to the second

half of that recommendation -- that you recommend legis-

lation to ensure, and you have dealt with this subject

really in part in answering the gentleman's question. I

am now concerned not with provincial legislation which

was discussed earlier, but I am interested in the matter

of how this relates to the role of the Federal Government.

What did you have in mind that the Commission

could recommend to the Federal Government as to changes

in Federal legislation that would take account of the

point which you have in mind now?

MR. STEWART: Would you repeat your question,

please?

COMMISSIONER FISHBURN: Parliament is suggested

that the Commission should also recommend, and I take it

recommend to the Federal Government --

MR. STEWART: Yes.

COMMISSIONER FISHBURN: Then I quote:

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MR. STEWART: This does not really require

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health scheme implemented by the Federal Government for

participation by the provinces, the Federal Government





Strachan

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would require the provinces to pass provincial legislation. That, in essence, is the impact of it.

COMMISSIONER FIRESTONE: This is very helpful, because what you are suggesting is that if we were to make recommendations to the Government we should bear in mind that the terms under which the Federal Government might make assistance available to the provinces should include a provision of the account which you have recommended. Is that your point?

MR. STRACHAN: That is the point, yes.

COMMISSIONER FIRESTONE: Therefore, you are not insisting on Federal Legislation to be passed?

MR. STRACHAN: No. As a matter of fact, I do not think the Government can pass the legislation to do it, but it can say the provinces must pass it, if they are going to participate.

COMMISSIONER FIRESTONE: You have clarified your situation very helpfully, sir.

May I turn to Paragraph 7 on page 2. Mr. Strachan, you referred a little earlier to the situation which is described in this paragraph 7, and you have said that you would that if a similar situation were to develop your hope would be that history would not repeat itself?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Now, sir, we come to this field of a hypothetical situation, because at this stage history has not as yet repeated itself. But, assuming such a situation were to develop, and legislation were introduced to provide for such medical care



would require the provinces to pass provincial legis-

lation. That, in essence, is the impact of it.

COMMISSIONER FIRSTOW: This is very help-

ful, because what you are suggesting is that if we were

to make recommendations to the Government we should bear

in mind that the terms under which the Federal Government

might make assistance available to the provinces should

include a provision of the amount which you have recom-

mended. Is that your point?

MR. STRACHAN: That is the point, yes.

COMMISSIONER FIRSTOW: Therefore, you are

not insisting on Federal legislation to be passed?

MR. STRACHAN: No, as a matter of fact, I

do not think the Government can pass the legislation to

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COMMISSIONER FIRSTOW: You have clarified

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Strachan

5864

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3 services, and you yourself would be the Premier of the  
4 Province, and you would have the doctors -- and I quote:  
5 "Officially notifying the Premier...". This is not the  
6 full quote, because the word "then" is included here.  
7 That, "The profession would not practise within the  
8 framework of the Act."

9 What would you do with such a situation, sir?

10 MR. STRACHAN: Well, I do not know what  
11 happened at this particular time. I am of the opinion  
12 that the Government capitulated. I am of the opinion  
13 the Government of the day capitulated. I have in mind  
14 a similar situation which developed at one stage of the  
15 game in Britain, where the doctors indicated they were  
16 going to refuse to operate within the framework of the  
17 Act. By subsequent meetings, the Minister of Health in  
18 Britain was able to impress upon the doctors assembled  
19 the importance of the legislation and what it meant to  
20 Britain.

21 I believe that if this same situation deve-  
22 loped that out of a series of meetings the medical pro-  
23 fession would go along with such a scheme. I have en-  
24 ough faith in the doctors of this province to say that.  
25 This is putting a lot of trust in them, but I have a lot  
26 of trust in them.

27 COMMISSIONER FIRESTONE: In other words, your  
28 answer is that if you were the Premier at that time and  
29 faced such a situation, you would use of means of per-  
30 suasion rather than means of compulsion. Is that your  
statement?

MR. STRACHAN: Right.





services, and you yourself would be the Premier of the  
Province, and you would have the doctors -- and I quote:  
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this quote, because the word "then" is included here.  
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What would you do with such a situation, sir?  
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Answer is that if you want the Premier at that time and  
faced such a situation, you would use of means of pers-  
uasion rather than means of compulsion. Is that  
statement?



Strachan

5865

COMMISSIONER FIRESTONE: May I turn to paragraph 4 on page 5:

"Drugs must be supplied to the patient at cost. This would, of course, mean public ownership of the drug manufacturing industry and drug distributing, with supplies to the patient continuing through local drug stores."

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Would it be a fair question to ask you that if your party were forming the government of British Columbia that you would wish to expropriate drug manufacturers in the Province of British Columbia and drug wholesale distributors in order to implement the recommendation in paragraph 4?

If you feel this would be an awkward question, by all means feel free to say you do not wish to answer the question.

MR. STRACHAN: The question you ask me, if we were the Government of British Columbia would we expropriate the drug manufacturers in this Province?

COMMISSIONER FIRESTONE: And wholesale drug distributors.

MR. STRACHAN: Yes. Not necessarily, but we would certainly set up a wholesale drug distribution system for use in the hospitals, and to make available to the hospitals and the people generally, drugs at a more reasonable price than has been the case in the past. And bearing in mind, also, that there is presently a Federal inquiry of some kind into the cost of drugs.

COMMISSIONER FIRESTONE: We are familiar,



COMMISSIONER FRANKLIN: May I turn to para-

graph 4 of page 2.

"During recent years supplied to the patient at cost. This would, of course, mean public ownership of the drug manufacturing industry and drug distributing, with supplies to the patient continuing through local drug stores."

MR. STEWART: Yes.

COMMISSIONER FRANKLIN: Would it be a fair

question to ask you that if your party were forming the government of British Columbia that you would wish to expropriate drug manufacturers in the Province of British Columbia and drug wholesale distributors in order to implement the recommendation in paragraph 4?

MR. STEWART: I feel this would be an awkward question by all means but I feel to say you do not wish to answer the question.

MR. STEWART: The question you ask is, if we were the Government of British Columbia would we expropriate the drug manufacturers in this Province? COMMISSIONER FRANKLIN: And wholesale drug

distributors.

MR. STEWART: Yes. Not necessarily, but we would certainly set up a wholesale drug distribution system for use in the hospitals, and to make available to the hospitals and the people generally, drugs at a more reasonable price than has been the case in the past. And bearing in mind, also, that there is presently a Federal inquiry of some kind into the cost of drugs. COMMISSIONER FRANKLIN: We are familiar,





Strachan

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3 sir, with this inquiry.

4 If I may come back to the subject again, sir.  
5 You referred to the fact that you would set up a publicly  
6 owned and operated distribution of drugs. Am I correct in  
7 that?

8 MR. STRACHAN: Right.

9 COMMISSIONER FIRESTONE: Would you have that  
10 system compete with private suppliers?

11 MR. STRACHAN: They would depend, I would  
12 think, on the private suppliers. You see, most of the  
13 drugs used in this Province are not made in this Province.  
14 They are bought from outside the Province or outside the  
15 Country, so it is largely a matter of wholesale. Notice  
16 I am suggesting going into the retail field of drugs.  
17 To be sure, there is a basic system of distributing drugs  
18 throughout the Province at the lowest possible price.

19 COMMISSIONER FIRESTONE: Well now sir, would  
20 you then be in favour of having a public distribution  
21 system compete with a private distribution system or  
22 would you say nobody is allowed to distribute drugs pri-  
23 vately, on a wholesale level in the Province so the  
24 public distribution system would have a monopoly? This  
25 has happened in a number of fields and it is just a  
26 question of what your views are?

27 MR. STRACHAN: That is a difficult question  
28 to answer. This would depend on the situation at the  
29 time and it is a difficult question to answer -- it  
30 would depend on the attitude of the drug wholesaler firm.

COMMISSIONER FIRESTONE: Presumably the drug  
wholesalers would want to stay in business if they enjoy





Strachan

5867

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3 a choice of staying in business or getting out of busi-  
4 ness and if the Government says they will only be  
5 distributed through a public distribution system they  
6 would be out of business so if the Government says that  
7 public wholesale drug distribution will distribute at  
8 cost you would think the private wholesaler would not be  
9 able to stay in business very long.

10 MR. STRACHAN: It would depend on the private  
11 wholesaler.

12 COMMISSIONER FIRESTONE: How about drug manu-  
13 facturers? Are there any drugs manufactured in British  
14 Columbia?

15 MR. STRACHAN: Very little, most of them are  
16 imported from the United States and other parts of Canada.

17 COMMISSIONER FIRESTONE: If you found there  
18 are certain drugs manufactured in the Province would you  
19 expropriate these?

20 MR. STRACHAN: Not necessarily, no.

21 COMMISSIONER FIRESTONE: In other words, you  
22 would then not go so far as you have gone in your recom-  
23 mendation which says that you require public ownership  
24 of drug manufacturing.

25 MR. STRACHAN: That is basically the recom-  
26 mendation at the national level. Basically a recom-  
27 mendation on a national level and, of course, as I say,  
28 very few of the drugs are manufactured in this Province.

29 COMMISSIONER FIRESTONE: In other words,  
30 would you feel that both drug manufacturing industries  
and drug wholesalers at the national level should become  
publicly owned?





a choice of staying in business or getting out of business and if the Government says they will only be distributed through a public distribution system they would be out of business so if the Government says that public wholesale drug distribution will distribute at cost you would think the private wholesalers would not be able to stay in business very long.

MR. STANLEY: It would depend on the private wholesalers.  
COMMISSIONER FRANKLIN: How about drug manu-

facturers? And there are drug manufacturers in British Columbia?

MR. STANLEY: Very little, most of them are imported from the United States and from parts of Canada.  
COMMISSIONER FRANKLIN: If you found that

the certain drugs manufactured in the provinces would you

MR. STANLEY: Not necessarily, no.

COMMISSIONER FRANKLIN: To what would you would then go so far as you have come in your recommendation which says that you require public ownership of a pharmaceutical?

MR. STANLEY: That is basically the recommendation at the national level, basically a recommendation of a national level and, of course, as I say, very few of the drugs are manufactured in this province.

Would you tell me what drug manufacturing industries and drug wholesalers at the national level should become publicly owned?



Strachan :

5868

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: But would you feel in the Province of B.C. within your own jurisdiction you would not want to go as far as you have recommended the Federal Government should go?

MR. STRACHAN: Right.

COMMISSIONER FIRESTONE: Is that correct?

MR. STRACHAN: That is right.

COMMISSIONER FIRESTONE: Thank you, that is a very helpful and forthright answer and is greatly appreciated. Now, I understand from what you are saying you would be largely concerned in the Province with distribution and public ownership in order to move the whole-sale distribution cost down to a basic minimum and you would achieve this by two methods; there are many methods but perhaps we can mention two. First it would be by centralized buying and a more efficient distribution, and, secondly, by changing the profit margin and you would pass on the benefits to the retailer?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: This would be one way of reducing the costs from the manufacturer or the importer down to the retailer?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Now, are you familiar that the largest portion of increases in costs from the time they leave the manufacturer to the time they reach the patient do not take place at the wholesale level but take place at the retail level? Are you familiar with this fact?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: But would you feel in the Province of B.C. within your own jurisdiction you would not want to go as far as you have recommended the Federal Government should go?

COMMISSIONER FIRESTONE: Is that correct?

MR. STRACHAN: That is right.

COMMISSIONER FIRESTONE: Thank you, that is a very helpful and forthright answer and is greatly appreciated. Now, I understand from what you are saying you would be largely concerned in the Province with distribution and public ownership in order to move the whole case of distribution over from a basic minimum and you would achieve this by two methods; there are many methods but perhaps we can mention two. First it would be by centralized buying and a more efficient distribution, and, secondly, by changing the profit margin and you would pass on the benefits to the retailers?

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MR. STRACHAN: Yes.

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that the largest portion of increases in costs from the time they leave the manufacturer to the time they reach the retailer do not take place at the wholesale level but take place at the retail level? Are you familiar with this fact?





Strachan

5869

MR. STRACHAN: The retailers, as I understand it, deny that that is so, in this Province, at least.

COMMISSIONER FIRESTONE: This would be interesting information and if you have information to this effect could this information be made available to the Commission? This runs contrary to the information we received in other provinces and if the situation in British Columbia is different, we would like very much to learn about it.

MR. STRACHAN: I thought I had referred to that in my section on drugs but I have not.

COMMISSIONER FIRESTONE: We would like to be helpful to you and if the information has been made available to you and you wish to make it available to us subsequently it would be entirely satisfactory to this Commission.

MR. STRACHAN: I did not mention that in the Section. The druggist told us that 30 percent of prescriptions are never filled mainly because the patients cannot afford them.

COMMISSIONER McCUTCHEON: That does not bear on Dr. Firestone's question, though.

COMMISSIONER FIRESTONE: It is a helpful observation that perhaps we have not developed adequate plans to assure the pre-payment. On this cost question would it help you if I were to give you the information that was given to us in other provinces which are subject to verification in the light of the experience of the practice in British Columbia?

MR. STRACHAN: Certainly.



MR. STANLEY: The witness, as I understand

it, says that there is no, in this Province, at least,

COMMISSIONER: That would be in-

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this office could this information be made available to

the Commission. This was contrary to the information

we received in other provinces and if the situation in

British Columbia is different, we would like very much

to learn about it.

MR. STANLEY: I thought I had referred to

that in my section on drugs but I have not.

COMMISSIONER: That would be

referred to you and if the information has been made

available to you and you wish to make it available to us

independently it would be entirely satisfactory to this

Commission.

MR. STANLEY: I did not mention that in the

section. The hospital told us that 80 percent of these

patients are never filled with because the patients

cannot afford them.

COMMISSIONER: That does not bear

on Mr. Peterson's question, does it?

MR. STANLEY: It is a helpful

observation that perhaps we have not developed adequate

plans to answer the cost question. On this cost question

would it help you if I were to give you the information

that was given to us in other provinces which was

just a verification in the light of the experience of

the witness in British Columbia?

MR. STANLEY: Yes.



Strachan

5870

COMMISSIONER FIRESTONE: As you realize, this is our first day of Hearings in British Columbia and we have not had the pleasure and opportunity of questioning the pharmaceutical profession yet but we plan on doing that. However, we would like to have your views dealing with the principle which we want to correct or appropriately adjust in the light of the factual information given to us. If I may, therefore, base my question on the basis of information given to us in other provinces just to give you a perspective. We were told in the Province of Alberta that on a prescription of \$1.00 list price the cost to the pharmacist is .60¢ and mark-up is .40¢. In addition to that he adds, in Alberta, a dispensing fee of about .75¢ or \$1.00 and, therefore, the .60¢ cost prescription reaches the patient at \$1.75 to \$2.00. Now, this works out to a mark-up including the overhead and the margin and the professional fee of the pharmacist of something like 200 percent on the cost of the drug. Now, if the drug were to cost \$10.00 then the original cost might be \$6.00, the mark-up \$4.00, the fee .75¢ or \$1.00 and it works out to about \$5.00 or about 85 percent. The story we have been getting in other provinces is that depending on the cost of the drug, the mark-up at the retail level, allowing for the fees and the further mark-up will vary something between 85 percent to 200 percent. Now, you will probably find that the mark-up at the wholesale level only, that is not counting the manufacturing cost, may be somewhat below that range, and, therefore, it appears on the surface and subject to verification on the evidence that



surface and subject to verification on the evidence that below that range, and, therefore, it appears on the not counting the manufacturing cost, may be somewhat that the mark-up at the wholesale level only, that is 85 percent to 200 percent. Now, you will probably find fees and the further mark-up will vary something between drugs, the mark-up at the retail level, allowing for the other provinces is that depending on the cost of the about 85 percent. The story we have been getting in fee, 75¢ or \$1.00 and it works out to about \$2.00 or original cost might be \$6.00, the mark-up \$4.00, the the drug. Now, if the drug were to cost \$10.00 then the pharmacist of something like 200 percent on the cost of overhead and the margin and the professional fee of the to \$2.00. Now, this works out to a mark-up of 200 percent the 60¢ cost prescription reaches the patient at \$1.75 dispensing fee of about .75¢ or \$1.00 and, therefore, up is .90¢. In addition to that he adds, in Alberta, a last price the cost to the pharmacist is .60¢ and mark-up the Province of Alberta that on a prescription of \$1.00 vices just to give you a perspective. We were told in on the basis of information given to us in other pro- ation given to us. If I may, therefore, base my question approximately adjust in the light of the actual information dealing with the principle which we want to correct on on doing that. However, we would like to have your views questioning the pharmaceutical profession yet but we also and we have not had the pleasure and opportunity of this is our first day of hearings in British Columbia

COMMISSIONER FIRESTONE: As you realize,



Strachan

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the area of cost saving that might be made to a large extent is in retailing drugs. Have you any suggestions, to bring down the cost through more efficient retailing? As well, presumably you are in favour of getting to the patient drugs at the lowest possible cost and that presumably covers the wholesale level and the retail level as well?

MR. STRACHAN: Well, I understand the druggists operate on a suggested price formula.

COMMISSIONER FIRESTONE: Yes.

MR. STRACHAN: They have a book of some kind that they refer to and it may be the suggested price formula is higher than it should be remembering too that costs at every stage up the ladder are usually a percentage mark-up of some initial cost. I am hoping that this enquiry into the price of drugs will indicate that the basic mark-up at the plant level is several hundred percent higher than it should be and if that basic mark-up at the plant level was brought down to a lower figure than a percentage mark-up of 10 cents or 15 cents it is much less than a percentage mark-up of 60 cents or \$1. and this finally would start them from a much lower point and still leave the percentage mark-up the same but the cost to the man using the drug is about one-quarter of what it now is. That is what we have to find out.

COMMISSIONER FIRESTONE: Are you aware that something like 90 percent to 95 percent of our drugs are imported from abroad?

MR. STRACHAN: As I say, I know a lot of

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Strachan

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3 them are.

4 COMMISSIONER FIRESTONE: It is a very large  
5 proportion?

6 MR. STRACHAN: Yes.

7 COMMISSIONER FIRESTONE: How would you con-  
8 trol the cost of imported drugs?

9 MR. STRACHAN: Well, the government may have  
10 to encourage -- if this is true it may be someone has a  
11 gun to our head and we should do something about it and  
12 set up plants in Canada to make these drugs.

13 COMMISSIONER FIRESTONE: You appreciate the  
14 reason we are importing such large quantities of drugs  
15 is that to produce the same drugs in Canada would cost  
16 more, not in all cases because we have had some cases  
17 where Canadian manufacturers have given competition but  
18 the very fact that a large proportion of our drugs is  
19 imported is in part based on the advantages of large  
20 scale production which other countries have and the fact  
21 is that we would have to create a drug manufacturing in-  
22 dustry in Canada whose costs would be somewhat higher.  
23 Would you be in favour of such a system?

24 MR. STRACHAN: I would be in favour of the  
25 creation of a drug system, a drug manufacturing plant in  
26 Canada. In all probability the large portion of the cost  
27 involved in drug production and distribution can be found  
28 in doctors' offices from one end of the country to the  
29 other, where practically every doctor has cupboards stuffed  
30 tight with free samples and I do not know but what all  
that is being paid for by the consumer and the doctors  
do not know what to do with them there are so many of





Strachan

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3 them. I think my doctor friends will agree with me that  
4 every day they are being besieged by private drug sup-  
5 pliers from the United States. Here again perhaps the  
6 drug manufacturing industry has not yet achieved a sense  
7 of purpose that suits the social purpose of the 1960's  
8 and perhaps this is what is required. Perhaps we can  
9 provide them with a sense of social purpose and this  
10 would be a basic step in getting the price of drugs down.

11 COMMISSIONER FIRESTONE: I take it from what  
12 you are saying to deal with high prices of imported drugs  
13 you would like to see a drug manufacturing industry  
14 established in Canada and if you cannot get private  
15 industry to do it you would be in favour of publicly-  
16 owned drug manufacturing industry in Canada which would  
17 eliminate some of the things which apparently you con-  
18 sider frills such as undue advertising, free samples  
19 and other practices. Is that what you have in mind?

20 MR. STRACHAN: Right.

21 COMMISSIONER FIRESTONE: To go back for a  
22 moment to the question of retail distribution, even if  
23 you are able to reduce as a result of, say, the sort of  
24 scheme that you have proposed, publicly owned, publicly  
25 controlled manufacturing funds in Canada of drugs. Let  
26 us say you are able to reduce the cost of more expensive  
27 drugs from \$10.00 per hundred to \$5.00 per hundred it  
28 would be a remarkable achievement in many instances from  
29 the point of view of substantial percent mark-ups at the  
30







Strachan

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3 retail level plus fees to the pharmacist. Have you any  
4 suggestions on how to bring down drug costs at the vari-  
5 ous levels? As I understand you want a drug cost to the  
6 patient at the lowest possible cost?

7 MR. STRACHAN: Right.

8 COMMISSIONER FIRESTONE: Presumably this in-  
9 volves effort at all levels, manufacturing, wholesaling  
10 and retailing. We have had suggestions from you at the  
11 manufacturing and wholesaling level, have you any sug-  
12 gestions on the retail level?

13 MR. STRACHAN: As I mentioned once, you  
14 would start at the bottom of the ladder reducing basic  
15 costs or percentages from out of an amount much less.  
16 You have admitted that retail druggists operate from a  
17 suggested price and if they start with the lower price  
18 than we are now starting from this means we arrive at  
19 a much lower cost, therefore, your suggested retail  
20 prices would be considerably lower than they are now. I  
21 understand druggists stick very close to these prices.

22 COMMISSIONER FIRESTONE: You have said if  
23 the cost of the wholesaler and the manufacture of drugs  
24 is reduced the result would be the price to the consumer  
25 would be reduced. This is quite correct. However, are  
26 you suggesting you would want to do nothing to bring  
27 down the costs at the retail level because that is the  
28 implication of what you are saying.

29 MR. STRACHAN: As I told you, I understand  
30 the druggists operate from a suggested price book and  
because of the change in circumstances and the change in  
the price level all the way up the suggested price book

retail level plus fees to the pharmacist. Have you any suggestions on how to bring down drug costs at the various levels? As I understand you want a drug cost to the patient at the lowest possible cost?

MR. S. RABINOWITZ: Right.

MR. S. RABINOWITZ: We have had suggestions from you at the retail level, and wholesaling level, have you any suggestions on the retail level?

MR. S. RABINOWITZ: As I mentioned once, you would start at the bottom of the ladder reducing basic costs on percentages. Now out of an amount which you have suggested that retail druggists operate from a suggested price and if they start with the lower price than we are now starting from this means we arrive at a much lower cost, therefore, your suggested retail prices would be considerably lower than they are now. I understand druggists stick very close to these prices.

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Strachan

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would be considerably lower than it now is.

COMMISSIONER FIRESTONE: Would you suggest that this publicly owned manufacturer having eliminated a wholesaler or perhaps working through a British Columbia wholesaler would then suggest to the retail pharmacist that his mark-up should be less than it is at present? At present it is, as I suggested, on a \$1.00 drug it is .40¢ or 40 percent of the list price. Would your suggestion then be this should be less or the suggested list price should be somewhat lower and so there would be a saving at the retail level as well?

MR. STRACHAN: That is what I just said.

COMMISSIONER FIRESTONE: I am glad that you explained to me so I now understand that you are in favour of price reduction on drugs at all levels, the manufacturer's level, the wholesale level and the retail level. At the retail level this would be involved in reducing the margin which the retailer charges of cost or as a percentage of the suggested list price?

MR. STRACHAN: Within the same percentage. Most retail businesses operate on a percentage mark-up on costs that vary from business to business so within the same percentage because you are operating through a lower unit, a lower retail price would mean less in dollars and cents to the retailer.

COMMISSIONER FIRESTONE: Your arithmetic is wonderful, I really admire you for it but I take it you would not only be in favour of the revenue but also in favour of a smaller percentage mark-up?

MR. STRACHAN: Not necessarily a smaller





Strachan

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percentage.

COMMISSIONER FIRESTONE: I am trying to establish what you are in favour of if you are not in favour of a smaller mark-up, all you have to do is just say so.

MR. STRACHAN: I say not necessarily.

COMMISSIONER FIRESTONE: What are you in favour of then? Are you in favour of the mark-up, the same percentage mark-up or a reduced mark-up? What are you in favour of?

MR. STRACHAN: Well, to answer that question, I would rather wait until I get the report of this inquiry in the price of drugs.

COMMISSIONER FIRESTONE: In other words, just in fairness to you, Mr. Strachan, and we are sincerely interested in your views, not trying to get one particular point of view or another, if I understand you correctly, your over-all object is to have the price of drug costs -- is to have the lowest possible drug cost as far as the physician is concerned?

MR. STRACHAN: That is right.

COMMISSIONER FIRESTONE: You will want to develop it on three levels, manufacturer, wholesale and retail.

MR. STRACHAN: Right.

COMMISSIONER FIRESTONE: As you have explained you want a method to achieve it at the retail level. You made clear the manufacturer and wholesale.

MR. STRACHAN: That is right.

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Strachan

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statement. Thank you very much, sir.

MR. STRACHAN: Remembering too that the majority, as a matter of fact, all the hospitals in this Province are under a hospitalization insurance scheme, and the large amount of drugs that are used within the operation and as part of the operating costs of hospitals in this Province, it is a major field of saving to the Province as a whole.

COMMISSIONER FIRESTONE: Thank you. May I now turn to another question. You must be very far-sighted, you anticipated my next question by referring to the hospital insurance scheme. Are you satisfied with the way this scheme is working?

MR. STRACHAN: Hospitals in the Province?

COMMISSIONER FIRESTONE: In the Province of British Columbia, and if not, have you any suggestions to make as to how to improve it?

MR. STRACHAN: Well, I think the hospitalization insurance scheme that is now operating in the Province of British Columbia is probably on a par with the best in Canada. The hospitalization insurance scheme has removed this financial fear the people have had in the past about going to hospitals. I am of the opinion that perhaps we haven't been building hospitals as best we should have been. This is a matter of fiscal policy and financial need. We have had a crucial time with hospitals in the Province, largely a matter of costs and Governmental attitude toward this cost. We have a \$1.00 per day limited co-insurance. There was a recent suggestion that because the Hospital Boards are confined



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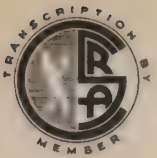
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Strachan

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3 within the per diem without adequate depreciation charges  
4 being allowed, that makes, provides some difficulties  
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6 per diem allowance from the B.C. Hospital Service. I  
7 am inclined to recognize their attitude there. Generally  
8 speaking the Hospital Insurance in this Province has  
9 been a terrific boon to the people.

10 COMMISSIONER FIRESTONE: Have you any specific  
11 suggestions to make as to the way we as the people who  
12 are expected to make recommendations to the Federal  
13 Government, whether there is something we should recom-  
14 mend to the Federal Government with respect to improve-  
15 ment as far as the present existing scheme is concerned  
16 or are you satisfied with the way it works?

17 MR. STRACHAN: There is continually a  
18 continuing pressure to expand the area under which the  
19 B.C. Hospital Insurance scheme now operates, nursing  
20 homes and chronic care. As our ability to keep alive  
21 increases then it increases the problem, not only fi-  
22 nancially, but it creates new problems within the family.  
23 I think there would be a social gain if we were able to  
24 provide real chronic care. I know it is not necessary,  
25 it does not necessarily mean a saving in acute hospitals  
26 because then all your patients in the acute are acute  
27 cases which would increase your cost, but you would have  
28 the others with a lower per diem cost. I think eventually  
29 we will have to provide for chronic care under  
30 hospitalization.

31 COMMISSIONER FIRESTONE: Do I understand  
32 you approve of this \$1.00 a day contribution by patients?

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COMMISSIONER FIRESTONE: Do I understand you approve of this \$1.00 a day contribution by patients?



Strachan

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MR. STRACHAN: I don't approve it. I don't disprove it. It is there. This \$1.00 a day, I don't think prevents people from going to the hospital. There are individual cases where even only the \$1.00 a day, some people find it a considerable amount of money. I don't think it presents a major problem.

COMMISSIONER FIRESTONE: You don't look at the \$1.00 as a deterrent fee?

MR. STRACHAN: I don't think it has acted as one.

COMMISSIONER FIRESTONE: Now, sir, if there is a suggestion that the \$1.00 should be increased to \$2.00, I understand from you, that there is some suggestion made this contribution should be made, would you support such an increase?

MR. STRACHAN: No, I wouldn't because you are starting again up the road that we left back in 1948 that an increase in co-insurance becomes the answer. You get from \$2.00 to \$4.00 to \$6.00 to \$8.00, eventually you are where you were. I wouldn't want to see it.

COMMISSIONER FIRESTONE: In other words, you are prepared to accept the \$1.00 as a token fee?

MR. STRACHAN: That is right.

COMMISSIONER FIRESTONE: But you don't wish to go any further?

MR. STRACHAN: No.

COMMISSIONER FIRESTONE: Now, sir, if the hospitals need more money and they cannot raise that dollar, where would you suggest that money should come from?



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Strachan

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COMMISSIONER FIRESTONE: In other words your suggestion would be that this should be obtained from taxation in one form or another rather than in the form of contribution by the users?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Well now, sir, if I understand your suggestion correctly, and applying the same principles of which you approved in the hospitalization scheme to a prepaid medical care plan, as I understand it, you are in favour of financing the plan somewhat along the lines that have been developed in the financing of the hospital insurance plan. Am I correct in this understanding of your proposal?

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: Now, under the hospital insurance plan there is a contribution of \$1.00 per day.

MR. STRACHAN: Yes.

COMMISSIONER FIRESTONE: You have suggested under the medical care plan that there should be no contribution by the patient. How do you reconcile those two views?

MR. STRACHAN: For one thing the patient goes to the hospital on the recommendation of a doctor. The patient doesn't get into the hospital until he has



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Strachan

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COMMISSIONER FIRESTONE: In other words, you would feel he shouldn't have to pay anything for that first call, that is an initial barrier to seeing the doctor. Would you be in favour of him making any payment at a subsequent occasion similar to the principle which is presently in operation in a hospital plan or would you feel that under no circumstances should those benefiting from a comprehensive medical care plan make any contribution directly to this plan?

MR. STRACHAN: No, I noted in my brief that I didn't think there should be any detriment. This is a double-sided coin.

COMMISSIONER FIRESTONE: Yes, it is.

MR. STRACHAN: If you have no detriment then the patient feels free to go to his doctor and I think we will agree doctors have been urging their patients, and these other forces as Professor Baltzan said, the Cancer Society have been urging people to go and see their doctor. That is the general attitude. Once they have gone to the doctor, I think the doctor should be free to see the patient as often as he, the doctor feels necessary, to drop in at their home when he happens to be making his rounds without the doctor having the feeling the patient would be left with the idea he is calling on the patient to get the dollar or the two dollars, or whatever it is. It is a two-sided coin. I don't think there should be any deterrent.



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Strachan

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3 COMMISSIONER FIRESTONE: In other words, sir,  
4 we should therefore read your recommendations, which you  
5 have made in this report to us, in this brief to us,  
6 that the principle of health insurance should apply to  
7 the financing of the medical care plan but we should add  
8 to that, excluding a direct contribution by the patient.

9 MR. STRACHAN: Yes.

10 COMMISSIONER FIRESTONE: You see in the  
11 hospital plan they are making a contribution, therefore,  
12 we are trying to understand what your views are. Would  
13 it be fair to say what you have in mind would be ex-  
14 cluding a direct contribution to the medical care plan  
15 even though you approve direct contribution to the  
16 hospital plan?

17 MR. STRACHAN: That is right.

18 COMMISSIONER FIRESTONE: Thank you, sir. If  
19 we could pursue this question of financing a little  
20 further. After all these plans have to be paid for.  
21 If I understand you correctly, sir, you are visualizing  
22 a Federal-Provincial plan. Am I correct?

23 MR. STRACHAN: Right.

24 COMMISSIONER FIRESTONE: And the form this  
25 Federal-Provincial plan would take, would be that the  
26 Federal Government would make a financial contribution  
27 to a plan administered by the Province?

28 MR. STRACHAN: Right.

29 COMMISSIONER FIRESTONE: What would you  
30 consider a reasonable contribution by the Federal  
Government to the Province? Again, if I read your brief  
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4 cent contribution. Am I right in that understanding?

5 MR. STRACHAN: I wouldn't want to state the  
6 exact percentage, but I would like to see the Federal  
7 Government pay about 60 percent in this field.

8 COMMISSIONER FIRESTONE: Well now, sir, this  
9 is another area where the application of the general  
10 statement that you would want to use the principle of the  
11 hospital insurance programme does not apply because in  
12 that case it is 50 percent or a little below. This is  
13 very helpful, Mr. Strachan. You realize in your oral  
14 presentation you are really amplifying and clarifying  
15 some of the things you have said. It is very important  
16 to us we understand what your recommendations are.

17 MR. STRACHAN: I think you will find when  
18 the Federal participation was set up that most of the  
19 provinces wanted the Federal Government to pay more than  
20 50 percent of the over-all cost of the hospitalization.

21 COMMISSIONER FIRESTONE: Do I take it if a  
22 50 percent offer were made and you were Premier of the  
23 Province of British Columbia that would be acceptable?

24 MR. STRACHAN: That would certainly be  
25 acceptable, you bet it would.

26 THE CHAIRMAN: We are discussing hypothetical  
27 questions.

28 MR. STRACHAN: I hope that is not too  
29 hypothetical.

30 COMMISSIONER FIRESTONE: You understood, Mr.  
Strachan, when we started out we agreed there would be  
a number of hypothetical questions.



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statement that you would want to use the principle of the  
hospital insurance programs does not apply because in  
that case it is 50 percent or a little below. This is  
very helpful, Mr. Strachan. You realize in your oral  
presentation you are really amplifying and clarifying  
some of the things you have said. It is very important  
to us we understand what your recommendations are.

MR. STRACHAN: I think you will find when

the Federal participation was set up that most of the  
provinces wanted the Federal Government to pay more than  
50 percent of the over-all cost of the hospitalization.  
COMMISSIONER FIRSTONE: Do I take it if a

50 percent offer were made and you were Premier of the  
Province of British Columbia that would be acceptable?

MR. STRACHAN: That would certainly be

acceptable, you bet it would.

THE CHAIRMAN: We are discussing hypothetical

MR. STRACHAN: I hope that is not too

hypothetical

Strachan, when we started out we agreed there would be  
a number of hypothetical questions.





Strachan

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MR. STRACHAN: Quite a few of them, too. Go ahead.

THE CHAIRMAN: We will take a recess till two o'clock. Is that agreeable to you, Mr. Strachan? Can you come back?

MR. STRACHAN: The house convenes at two. Are there going to be very many more questions? I would rather finish now.

COMMISSIONER FIRESTONE: Could we continue for fifteen minutes.

MR. STRACHAN: I would rather continue.

COMMISSIONER FIRESTONE: Could we have your indulgence for another fifteen minutes?

MR. STRACHAN: Certainly.

COMMISSIONER FIRESTONE: Very good, sir. If I may complete these questions on financing. It is one of those rather important questions, as you appreciate, sir. I understand that you would accept the federal government making a contribution. You would prefer 60 percent, but you would be prepared to accept 50 percent. Now, in order to pay, in order for the Federal Government to make this 50 percent contribution it will presumably have to raise the monies through taxes. Now, if this might mean increase in taxation rates and this might make it, perhaps, a little bit more difficult for the Provincial Government to collect taxes, because as we understand the Provinces have been saying to the Federal Government that they might vacate some of the taxation fields or leave some room for them which is an understandable position to hold. Obviously the money would have to come



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COMMISSIONER FIRESTONE: Could we adjourn for

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MR. STRACHAN: I would rather continue.

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MR. STRACHAN: Certainly.

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leave some room for them which is an understandable

position to hold. Obviously the money would have to come



Strachan

5885

from somewhere. This involves higher federal taxation.

How would you feel about that, sir.

MR. STRACHAN: Now, you are making it very difficult to answer that without moving over a certain line, sir. The policy in this Country to pay for such services are related almost exactly to its ability to produce real wealth, to increase the gross national product. As the gross national product goes up so does our ability to pay for these services. I wouldn't expect the Federal Government to enter in a scheme like this to continue with or be satisfied with the present inadequate national economic growth. I would expect the New Democratic Party Federal Government to implement an economic policy that would increase the gross national product in the rest of the Country. We would have no problem about financing this from the Federal Government then. You made it difficult to answer that question without going over the line.

THE CHAIRMAN: We are still in hypothetical questions.

COMMISSIONER FIRESTONE: Well now, sir, if I understand you correctly, and this is an approach that makes economic sense. I am not referring to the political implications of your answer. I am concerned with the economic reasoning behind it. If our gross national product rises rapidly the same taxation would provide larger revenue, and this larger revenue in part could be used to pay the increased health services. I think economically this makes sense. You realize that in the past we have had variations in the rate of economic



2882

STRAHAN

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Strachan

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3 growth and sometimes the Canadian economy grows, the  
4 national product rises a bit more rapidly and sometimes  
5 a bit more slowly. The problem is still, there is still  
6 a possibility of finding ways and means to meet the  
7 health service through increased taxation, either at the  
8 Federal level or at the Provincial level. If this situ-  
9 ation develops, and we are solely concerned with the  
10 economic situation, sir, would it be your view, would  
11 you feel that we should follow the principle of the  
12 ability to pay, and therefore if this principle, if this  
13 means higher taxation by those who are able to pay,  
14 you would be in favour or you wouldn't be in favour?

15 MR. STRACHAN: First of all I want to look  
16 at the implication inherent in your question. If you  
17 are saying we are going to require more money than is  
18 now being spent in order to achieve satisfactory health  
19 standards, then it means that many of our people are  
20 not now getting satisfactory medical attention. If  
21 anyone says we are now getting satisfactory medical  
22 coverage then it means it is being paid for now. Our  
23 basic problem is to re-organize the payments in such a way  
24 that everyone benefits from such a change. For in-  
25 stance, those who are now involved in a group scheme  
26 in this Province, M.S.A. pay somewhere in the neigh-  
27 bourhood of \$10.00 or \$11.00 per month, pay \$10.00 or  
28 \$11.00 per month for their present medical services.  
29 If to implement a national scheme it meant increase  
30 in taxation on the personal level you have to equate  
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Strachan

5887

individual now involved in one of these schemes wouldn't have to pay any more, or perhaps less than he is now paying. If you increased taxation, even in the present federal set-up, if you saved this \$11.00 paid to M.S.A., in my opinion, and that is paid partly by the employer

...

COMMISSIONER FIRESTONE: Dr. Strachan, as I understand it...

MR. STRACHAN: Dr. Strachan is over here. Some of my best friends are doctors.

COMMISSIONER FIRESTONE: I accept the qualification. Mr. Strachan, I take it that your proposal is based on an assessment of the situation which exists, that we don't have adequate medical service for everybody in British Columbia and in order to provide for this service we have to have a comprehensive national and provincial scheme. Presumably such a scheme would cost more than present payments for medical services because you would pay more than you are paying now.

MR. STRACHAN: That is right.

THE CHAIRMAN: Mr. Strachan, in your statement you have there about \$4 million more.

MR. STRACHAN: Yes.

THE CHAIRMAN: That is the figure he quoted. That is for B.C.

COMMISSIONER FIRESTONE: Whatever the figure is, I am more concerned with the principle, more money will be involved and that money will have to be raised.

MR. STRACHAN: Right.

COMMISSIONER FIRESTONE: If that means higher

individual now involved in one of these schemes wouldn't have to pay any more, or perhaps less than he is now paying. If you increase taxation, even in the present federal set-up, if you saved this \$11.00 paid to M.S.A., in my opinion, and that is paid partly by the employer

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MR. STRACHAN: That is right.

THE CHAIRMAN: Mr. Strachan, in your state-

ment you have there about 24 million more.

MR. STRACHAN: Yes.

THE CHAIRMAN: That is the figure he quoted.

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COMMISSIONER FINCHAM: Whatever the figure

is, I am more concerned with the principle, more money will be involved and that money will have to be raised.

MR. STRACHAN: Right.



Strachan

5888

taxes you would be in favour of it, to pay for it?

MR. STRACHAN: If it meant it would come out of taxation, yes. I am of the opinion that what will happen if such a scheme is implemented step by step the natural increase which we experience in this Province, and in any other province of Canada, in our normal revenue would be directed to it as it becomes available without an increase in taxes.

COMMISSIONER FIRESTONE: You would be prepared to support increased taxes if necessary?

MR. STRACHAN: Based on ability to pay.

COMMISSIONER FIRESTONE: Based on ability, that is fair and to the point, sir. What would happen, sir, to schemes that are presently in existence where the employer makes a contribution? What would happen to the employer's contribution under the proposal that you have in mind?

MR. STRACHAN: Well, under the present set-up the employer contribution is a cost item and it is part of the operating cost of his business before he pays taxes. Once you have removed the cost item then this moves to the other end. He will be paying more taxes and in other words it will be compensated for.

COMMISSIONER FIRESTONE: You wouldn't suggest, then, that the employer should make the payment to the employee representing his present contribution to a health scheme?

MR. STRACHAN: After careful consideration this may be the best way to do it.



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Strachan

5889

I don't want to say right now.

I am interested in cutting the red tape and the form-filling and all the rest of it out, eliminating as much of that as possible. Therefore, if it merely tends to be in his normal business practice without necessitating all kinds of forms I would rather have it that way.

COMMISSIONER FIRESTONE: And without adding this portion to the pay envelope of the employee?

MR. STRACHAN: Yes, yes.

COMMISSIONER BALTZAN: Now, you speak of a scheme which you feel would only be successful if it were compulsory. And compulsory, meaning, I presume, everybody in the Province of British Columbia?

MR. STRACHAN: Yes.

COMMISSIONER BALTZAN: This is what you have proposed?

MR. STRACHAN: Yes, that is right. And, bearing in mind the method by which the plan would be financed, not on a premium basis because I indicate in my brief I am opposed to a premium set-up.

THE CHAIRMAN: Or the matter of compulsion?

MR. STRACHAN: Everybody has to pay taxes, yes, but utilization of the scheme would be a matter of personal choice, you see. Under the old British Columbia Hospital Insurance scheme in this Province when it was based on a premium basis, we had a section there allowing people to contract out, for religious reasons. So that



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Strachan

5890

no one has to accept the benefits of it if they do not want to.

COMMISSIONER FIRESTONE: Now, sir, to come to the concluding part of the questioning. You are in favour of a compulsory plan for British Columbia, and you would like the Federal Government to make a contribution to such a plan.

Now, sir, this Royal Commission is here to advise the Federal Government on a plan that would be acceptable, that might be acceptable either to all ten provinces, but if not all the provinces at least to the majority of the provinces.

Now, some provinces may provide voluntary plans; some provinces may prefer to have no plan, and some provinces may prefer to have a compulsory plan. Now, -- and, again, we are still in the field of hypothetical questions -- let us assume that this Commission were to recommend and the Federal Government were to adopt a plan which would provide that these programmes would be provincially administered and provincially operated. That is the first condition. Secondly, it would leave it to the good judgement of each province whether they wish to make the plan voluntary or compulsory. And, thirdly, the Federal Government would require that certain minimum standards of medical care and health services be provided. And, fourthly, leaving it up to each province to decide how they wish to finance their plan -- premium, taxes, or what have you. Fifthly, requiring that those who wish to have a voluntary plan cover a majority of the population --



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Strachan

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3 obviously those that are compulsory cover everybody, and  
4 those who want it would cover a majority of people, 75  
5 percent, 85 percent, what have you. And if the majority  
6 of provinces representing the majority of the population  
7 of Canada came into such a plan, would you support such  
8 a proposal?

9 MR. STRACHAN: This would, then, as I gather  
10 your proposals, then give us a scheme where some provinces  
11 would have a health plan and some would not. Some would  
12 have it on a voluntary basis, probably through a premium.

13 COMMISSIONER FIRESTONE: It is up to them if  
14 they want a mixed system -- partial premium, partial  
15 taxes. We are leaving it to the provinces' good judgment  
16 to find the best system their people are willing to  
17 support. After all, if one province wants compulsory and  
18 one voluntary, could we not have a system in Canada which  
19 makes such a federal plan possible?

20 MR. STRACHAN: I think in at least one place  
21 in my brief I indicated I would prefer this kind of scheme  
22 in preference to no scheme at all, and on that basis I  
23 am quite prepared to say yes to all of your questions.

24 If the people of a province are prepared to  
25 make their contribution to the revenue of a federal  
26 government and prepared to sit back and not participate  
27 in the distribution of those revenues, that is their  
28 choice, but I do not think the people of British Columbia  
29 would want to be in that position.

30 COMMISSIONER FIRESTONE: May I say, sir, you  
have been very helpful, and thank you very much.

COMMISSIONER BALTZAN: Just two questions, and



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COMMISSIONER FRIESTON: May I say, sir, you have been very helpful, and thank you very much. COMMISSIONER BALDWIN: Just two questions, and



Strachan

5892

1 I will not question any of the answers, Mr. Strachan.

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4 Would you go to page 4. You refer there to  
5 group practice clinics. I take it your estimation on  
6 top of the page, last line, at the end of the paragraph  
7 --

8 MR. STRACHAN: Page 4 of the brief?

9 COMMISSIONER BALTZAN: I think it is page 4  
10 of the brief, yes. Paragraph 14 is on page 3, and I am  
11 referring to group practice on page 4.

12 MR. STRACHAN: Yes.

13 COMMISSIONER BALTZAN: In your estimation,  
14 I take it that group practice is to make more money, and  
15 my question to you is --

16 THE CHAIRMAN: Where is the reference. I  
17 would like to see it.

18 MR. STRACHAN: Oh, I see. The top of page  
19 4, the last three words on that paragraph "are presently  
20 group practice clinics."

21 No, not necessarily. I think --

22 COMMISSIONER BALTZAN: I have not put my  
23 question, sir.

24 MR. STRACHAN: I think I know what your  
25 question is. You preceded it by inferring that --

26 COMMISSIONER BALTZAN: Could this mean rather  
27 the reverse, a method of saving on the cost rather than  
28 a medical health service?

29 MR. STRACHAN: Yes, it could be a saving on  
30 the cost, but I think the best person to answer it would  
be the doctors, but in my opinion the group practice  
growth is due to two factors: One, to allow for more



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Strachan

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3 economical provision of medical services; and, two, to  
4 allow doctors a day of the week any time of the day or  
5 night. I think there were two factors and both factors  
6 are very laudable.

7 COMMISSIONER BALTZAN: I said there would be  
8 no questions -- I did not read what preceded that state-  
9 ment. Could group practise be developed on this basis  
10 for the benefit of the people as compared with the soli-  
11 tary doctor?

12 DR. STRACHAN: Oh, undoubtedly. Without  
13 question, it allows for this development. As a matter  
14 of fact, this was one of the suggestions made in the  
15 British scheme, that there be a co-relation of public  
16 and private health through the provision of comprehensive  
17 health centres.

18 As I understand it, this has not been pro-  
19 ceeded with in Britain, and this is one of the lacks  
20 showing up now over there.

21 COMMISSIONER BALTZAN: It is, therefore,  
22 not directly related to the last portion of paragraph  
23 14 on page 3.

24 THE CHAIRMAN: At the risk of prolonging  
25 this, we have heard nothing about the care of the  
26 mentally ill in British Columbia. Are you satisfied  
27 with the present situation insofar as care of the  
28 mentally ill and the crippled children, and so forth?

29 MR. STRACHAN: Well, I have not been, in  
30 the past. Here, you must remember that I am a layman.  
I have not got the medical education, but from the in-  
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MR. STRACMAN: Well, I have not been in the past. Here, you must remember that I am a lawyer. I have not got the medical education, but from the information that I am able to gather, I have been



Strachan

5894

dissatisfied with the care of the mentally ill in the past in the Province.

We have made tremendous strides. Just a year ago, I went through all the mental institutions in our Province, and there was no doubt they had made tremendous strides.

The Minister of Health the other day made a speech in the House that I felt indicated we were getting ready now to take tremendous steps forward in the care of the mentally ill in the Province of British Columbia. I am hopeful that we are on the way. It is a tremendous problem, of course.

THE CHAIRMAN: In the matter of just being able to do so much at any one time, would you give priority to providing physicians' services in British Columbia over what may be the needs of the mentally ill, or the mentally retarded, and all that group of citizens who fall into that type of category?

MR. STRACHAN: I think we have to move forward on a broad front. As this gentlemen asked me, over-all health -- this is part of the over-all health. The problem we have in British Columbia is finding adequately trained people who will do the work. This is a major problem in our Province.

THE CHAIRMAN: You see, what I am asking is do you give this limited aspect of physicians' services priority over the other areas of health services in British Columbia?

MR. STRACHAN: Well, of course you have to remember also that this is a presentation to a Federal







Strachan

5895

Royal Commission, so naturally I must give emphasis on those aspects of the question in which the Federal Government can participate.

Mental health is primarily a provincial responsibility, which is why I haven't --

THE CHAIRMAN: Every province that we have been till now has come to us and said that the mentally ill, the care of the mentally ill should be on the same basis as the physically ill.

MR. STRACHAN: Well, I would support -- if the Government says that of this government, I would support them on that.

THE CHAIRMAN: Not of this government, but that proposition has come forward by and large across the Country.

MR. STRACHAN: I would support that proposition.

THE CHAIRMAN: And the same with tuberculosis and --

MR. STRACHAN: Yes.

THE CHAIRMAN: But, I would still like to ask you, if I may, today what is the most urgent need in health services in the Province of British Columbia, in your view, Mr. Strachan?

MR. STRACHAN: Well, that is a very difficult question to answer, Mr. Chairman. It is a very difficult question to answer.

THE CHAIRMAN: There seems to be a great emphasis on the providing of physicians' services as, more or less, that if that situation was achieved, that the millenium more or less would be here?

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Mental health is primarily a provincial

responsibility, which as my I haven't --

THE CHAIRMAN: Every province that we have been till now has come to us and said that the mentally ill, the care of the mentally ill should be on the same basis as the physically ill.

MR. STRACHAN: Well, I would support -- if

the Government says that of this government, I would support them on that.

THE CHAIRMAN: Not of this government,

but that proposition has come forward by and large across the country.

MR. STRACHAN: I would support that proposition.

THE CHAIRMAN: And the same with tuberculosis

and --

MR. STRACHAN: Yes.

THE CHAIRMAN: But, I would still like to

ask you, if I may, today what is the most urgent need in health services in the Province of British Columbia, in your view, Mr. Strachan?

MR. STRACHAN: Well, that is a very diff-

icult question to answer, Mr. Chairman. It is a very difficult question to answer.

THE CHAIRMAN: There seems to be a great

emphasis on the providing of physicians' services as more or less, that if that situation was achieved, that the million more or less would be more?





Strachan

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MR. STRACHAN: I think there are idealistic stars; we do not expect to reach them, but the mariners use them for guidance. This is the idea we are speaking of.

THE CHAIRMAN: Your ideal is the providing of physicians' services?

MR. STRACHAN: Completely, yes. On page 5 I say: "A government medical care plan for Canada should be compulsory, comprehensive, and should cover every citizen."

THE CHAIRMAN: If you could only get those things one at a time, which one would you want first?

MR. STRACHAN: "It should include complete hospital care, both in-patient and out-patient treatment for acute and chronic conditions, psychiatric and tuberculosis care." And then I go on.

THE CHAIRMAN: If you cannot get them all at once, what is your area of greatest need, if you are in a position to answer, in the Province of British Columbia today?

MR. STRACHAN: In the Province of British Columbia, and as I say based on the speech made by the Minister in the House the other day.

THE CHAIRMAN: No, no. Just what is your view, from your knowledge of the Province, if you have an extensive knowledge, which I assume you have?

MR. STRACHAN: At this time, both comprehensive medical coverage for the average citizen and alongside it and equally important is the provision of better mental health care.

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alongside it and equally important is the provision of



Strachan

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THE CHAIRMAN: If you cannot get both at once, which would you want first?

MR. STRACHAN: I won't make a choice. I won't answer that question. They are both two forces in separate medical fields, and I think we should go forward in both of them.

THE CHAIRMAN: Others are expressing the view that they are not separate fields and that they are just the one field of health, and that it is the same whether it is mental or physical, and there should be no differentiation.

MR. STRACHAN: Those are the two; I think those are the two aspects of the over-all health question which should be driven forward.

THE CHAIRMAN: Thank you very much, Mr. Strachan, and Mr. Wood for your silent but no doubt effective contribution, and we will adjourn now until two o'clock.

---ADJOURNMENT







ch/ss1 ---On resuming at two o'clock.

2 THE CHAIRMAN: The first brief this  
3 afternoon is that of the Greater Victoria Metropolitan  
4 Board of Health.

5 THE SECRETARY: That will be Exhibit  
6 145.

7 ---EXHIBIT NO. 145: Submission of Greater  
8 Victoria Metropolitan  
9 Board of Health

10 A P P E A R A N C E S

11 G.K. SAMMON --Chairman

12 MR. C. C. WYATT

13 J.L.M. WHITBREAD, M.D., D.P.H.

14 MRS. P. KEHR

15 THE CHAIRMAN: Yes, Doctor Whitbread?

16 DR. WHITBREAD: Mr. Wyatt will present  
17 the Brief.

18 THE CHAIRMAN: Thank you.

19 MR. WYATT: The Greater Victoria  
20 Metropolitan Board of Health on November 15, 1961, author-  
21 ized the submission of a brief to the Royal Commission on  
22 Health Services and directed that such a brief be prepared.

23 The Greater Victoria Metropolitan  
24 Board of Health wishes to be represented at the hearing  
25 of the Royal Commission by:

26 Mr. C.C. Wyatt,  
27 Municipal Manager,  
28 City of Victoria.  
29 and  
30 Dr. J.L.M. Whitbread,  
Senior Medical Health Officer,  
City of Victoria.



---On resuming at two o'clock.

THE CHAIRMAN: The first brief this

afternoon is that of the Greater Victoria Metropolitan

Board of Health.

THE SECRETARY: That will be Exhibit

105.

---EXHIBIT NO. 105: Submissions of Greater Victoria Metropolitan Board of Health

O.K. BANNON --Chairman

MR. C. C. WYATT

THE CHAIRMAN: Yes, Doctor W. Whitbread.  
MR. WHITBREAD: Mr. Wyatt will present

the report.

THE CHAIRMAN: Thank you.

MR. WYATT: The Greater Victoria

Metropolitan Board of Health on November 15, 1961, authorized the submission of a brief to the Royal Commission on Health Services and directed that such a brief be prepared.

Board of Health wishes to be represented at the hearing of the Royal Commission by:

Mr. C.C. Wyatt,  
Municipal Manager,  
City of Victoria,  
and

Senior Medical Health Officer,  
City of Victoria.





1 The Greater Victoria Metropolitan  
2 Board of Health wishes to limit its brief to a discussion  
3 of the health needs of the chronically ill and the aged.

4 The Greater Victoria Metropolitan  
5 Board of Health wishes to discuss matters pertaining to  
6 the following terms of reference of the Royal Commission  
7 on Health Services given in Order-in-Council P.C. 1961 -  
8 883, specifically paragraphs (a), (b), (c), (e), (f), and  
9 (k).

10 The Greater Victoria Metropolitan  
11 Board of Health is comprised of duly appointed representa-  
12 tives from the elected official bodies - These are given  
13 in - Appendix I.

14 The Greater Victoria Metropolitan  
15 Board of Health administers public health services for the  
16 souther part of Vancouver Island which includes the City  
17 of Victoria, the Municipalities of Esquimalt, Oak Bay,  
18 Saanich, Central Saanich, the Village of Sidney and large  
19 areas of unorganized territory including certain of the  
20 Gulf Islands and the West Coast as far North as Port  
21 Renfrew. The total area provided with health services by  
22 the Greater Victoria Metropolitan Board of Health is  
23 approximately 600 square miles. The population served  
24 includes 85,700 in the urban area and 73,100 in the sub-  
25 urban and rural areas, a gross total of 158,800.

26 The Greater Victoria Metropolitan  
27 Board of Health provides a comprehensive public health  
28 service including a maternal and child health programme,  
29 school health services, communicable disease control and  
30 environmental health. Health education, mental health and





1 nutrition teaching are integrated into the appropriate  
2 services.

3 In addition, the urban area is provided  
4 with a bedside nursing service by a private agency, the  
5 Victorian Order of Nurses. The suburban and rural areas  
6 are given bedside nursing services by the public health  
7 nurses employed by the Saanich Branch of the Greater  
8 Victoria Metropolitan Board of Health. Certain outlying  
9 areas, the Gulf Islands and parts of the West Coast are  
10 excluded.

11 The Greater Victoria Metropolitan  
12 Board of Health limits its discussion to the provision of  
13 health services to the chronically ill and the aged and  
14 does so for the following reasons:

15 (1) Persons aged 65 years and over comprise 7.7% of  
16 the population of Canada as a whole. In the  
17 City of Victoria they comprise 19.6% of the popu-  
18 lation, and in the Metropolitan Area they form  
19 16.7% of the population. The rate is expected to  
20 be reduced in subsequent years but the actual  
21 numbers of people over 65 years is expected to  
22 increase. By 1976 the population over 65 years  
23 is expected to be 28,700 persons. The favorable  
24 location and mild climate which I suspect you  
25 have enjoyed entice people from all parts of  
26 Canada to come to the area to retire. These  
27 people are usually in the older age group and  
28 usually come without their adult children.

29 (ii) The number of people in the area served by the  
30 Greater Victoria Metropolitan Board of Health who





continued.

In addition, the urban area is provided with a bedside nursing service by a private agency, the Victorian Order of Nurses. The suburban and rural areas are given bedside nursing services by the public health nurses employed by the Sanitch Branch of the Greater Victoria Metropolitan Board of Health. Certain visiting areas, the Gulf Islands and parts of the West Coast are

Hand of Health limits its discussion to the provision of medical services to the chronically ill and the aged and does so for the following reasons:

Persons aged 65 years and over comprise 7.7% of the population of Canada as a whole. In the city of Victoria they comprise 19.6% of the population, and in the Metropolitan Area they form 16.7% of the population. The rate is expected to be reduced in subsequent years but the actual numbers of people over 65 years is expected to increase. By 1970 the population over 65 years is expected to be 26,700 persons. The favorable location and mild climate which I suspect you have enjoyed since people from all parts of Canada come to the area to reside. These people are mostly in the older age group and normally come without their usual ailments.

Greater Victoria Metropolitan Board of Health and



are 65 years or older is estimated at 26,000 at the present time. Chronic illness is generally considered to be markedly more prevalent in this age group than in any other age group.

The number of chronically ill and aged in Greater Victoria at present in institutions is approximately 1,000 (1,054 beds). The number of chronically ill in their homes is estimated at 2,000 - 3,000.

(iii) Despite safeguards set up in regulations, human need encourages physicians to place and keep chronically ill patients in general acute care hospitals for long periods. This causes an increasing shortage of beds in acute care hospitals.

(iv) The same humane and enlightened concepts for care of the chronically ill and aged, which are practised in Britain and in the Scandinavian countries, should influence health care for the same group in Canada.

(v) Because of the concentration of people over 65 years in the Greater Victoria area, the provision of hospital insurance, the interest of the provincial government in chronic care, the availability of two visiting nurse agencies, and an already functioning rehabilitation centre, this area should be helped to give leadership in Canada to a total programme of health care for the chronically ill and aged.

### 3. Existing Facilities

(1) ~~Acute~~ Care Hospitals - Four general hospitals



the present time. Chronic illness is generally considered to be markedly more prevalent in this age group than in any other age group.

The number of chronically ill and aged in Greater Victoria is present in institutions is approximately 1,000 (1,000 beds). The number of chronically ill in their homes is estimated at 2,000 - 3,000.

(iii) Despite safeguards set up in regulations, nurses need encourages physicians to place and keep

chronically ill patients in general and care hospitals for long periods. This causes an increasing shortage of beds in acute care hospitals.

(iv) The same disease and enlightened concepts for care of the chronically ill and aged, which are practised in Britain and in the Scandinavian countries, should influence health care for the same group in Canada.

(v) Because of the concentration of people over 65 years in the Greater Victoria area, the provision

of hospital insurance, the interest of the provincial government in chronic care, the availability of the visiting nurse association, and an

already functioning rehabilitation centre, this area would be well placed to give leadership in Canada to a total programme of health care for the chronically ill and aged.





1 accept chronic care patients only during episodes  
2 of acute illness or for the final stages of  
3 terminal care. Two of these hospitals are urban  
4 teaching hospitals with a present bed capacity  
5 of 887 (excluding bassinets). Two of the hos-  
6 pitals which are in communities serving rural  
7 populations have a combined total of 78 beds.  
8 There is a fifth hospital serving a segment of  
9 the population. This is a D.V.A. Hospital with  
10 a bed capacity of 300 of which 65 beds are desig-  
11 nated for geriatric patients. This is the only  
12 hospital with a special department of geriatrics.  
13 None of the hospitals has an outpatient department.  
14 All except the D.V.A. Hospital are under the con-  
15 trol of hospital boards as required by the  
16 Province of British Columbia Hospitals Act of  
17 1960.

18 (ii) Gorge Road Hospital - This former chronic care  
19 private hospital operating on a non-profit basis,  
20 since September, 1960, has developed a rehabili-  
21 tation, chronic care and convalescent programme  
22 under the extended care programme sponsored by  
23 the present provincial government. This has been  
24 considered a demonstration project for rehabili-  
25 tation or reactivation units. Patients pay the  
26 \$1.00 a day co-insurance as is required in the  
27 acute hospital. Remaining costs are paid by  
28 Provincial Government under B.C.H.I.S.  
29 There are 81 beds available for rehabilitative  
30 care of patients of all ages including Workmen's



of acute illness or for the final stages of terminal care. Two of these hospitals are under teaching hospitals with a present bed capacity of 687 (excluding psychiatric). Two of the hospitals which are in communities serving rural populations have a combined total of 76 beds. There is a fifth hospital serving a segment of the population. This is a D.V.A. Hospital with a bed capacity of 300 of which 25 beds are designated for geriatric patients. This is the only hospital with a special department of geriatrics. None of the hospitals has an outpatient department. All except the D.V.A. Hospital are under the control of hospital boards as required by the Province of British Columbia Hospitals Act of 1960.

(11) George Road Hospital - This former chronic care private hospital operating on a non-profit basis since September, 1960, has developed a rehabilitation, chronic care and convalescent programme under the extended care programme sponsored by the present provincial government. This has been

tion or reactivation units. Patients pay the \$1.00 a day co-insurance as is required in the acute hospital. Remaining costs are paid by provincial government under A.C.H.I.S. There are 61 beds available for rehabilitative care of patients of all ages including Women's



1 Compensation Board cases. Patients are referred  
2 by their own physician or the Workmen's Compen-  
3 sation Board to a three man medical screening  
4 board and are admitted if there is a reasonable  
5 expectation of some improvement. Patients are  
6 admitted for varying periods of two weeks to six  
7 months. Extensions are granted when indicated  
8 to consolidate or increase the gains made by the  
9 patient. The patient remains under the care of  
10 his own physician who has the responsibility of  
11 ordering the treatment. If specific orders are  
12 not given by the physician, the patient is placed  
13 under the care of the orthopedic consultant to  
14 the hospital.

15 (iii) Private Hospitals - These are profit-making  
16 institutions governed by the Provincial Hospitals  
17 Act of 1960. Patients pay from \$195 - \$300 per  
18 month or more. Welfare agencies pay the costs  
19 for patients on Social Assistance.  
20 These hospitals are inspected at least annually  
21 by non-medical hospital inspectors from B.C.H.I.S.  
22 Patients are given custodial care with a minimum  
23 of medical supervision. There are 9 such hospi-  
24 tals with 403 beds, in the Metropolitan area of  
25 Victoria. There are waiting lists for every  
26 private hospital.

27 (iv) Boarding Homes - These are profit making insti-  
28 tutions governed by the Welfare Institutions  
29 Licensing Act. They are inspected by various  
30 local authorities for the maintenance of physical







standards. There are 36 boarding homes with from 4 to 100 boarders and a total of 586 beds in the Metropolitan area of Victoria. They vary in quality and costs to boarders. Four non-profit boarding homes operate in the area. People in boarding homes may be given personal services, but professional nursing care is not given.

(v) Practising Physicians - There are approximately 228 physicians in the Greater Victoria area. They comprise general practitioners and specialists. There are a number of specialists in internal medicine, orthopedics, anaesthetists, public health etc. The crude ratio of population to doctors is 706:1.

(vi) Home Care Services

(a) Visiting Nurse Organizations - Two organizations, the Victorian Order of Nurses, serving the heavily populated urban area of 85,700 people, and the Saanich Branch of the Greater Victoria Metropolitan Health Department provide nursing care serving the suburbs and rural areas (excluding the Gulf Islands and parts of the West Coast) approximately 73,800 people. Victorian Order of Nurses services to the chronically ill are well known. Saanich nurses provide similar services but in addition to the preventive health work. There are 9 field staff in Victorian Order of Nurses and 19 field staff in Saanich. Both agencies strive to keep the patient independent and in his own home. Victorian Order of

standards. There are 36 boarding homes with from 4 to 100 boarders and a total of 586 beds in the Metropolitan area of Victoria. They vary in quality and costs to boarders. Four non-profit boarding homes operate in the area. People in boarding homes may be given personal services, but professional nursing care is not given. (v) Visiting Physicians - There are approximately 200 physicians in the Greater Victoria area. They comprise general practitioners and specialists. There are a number of specialists in internal medicine, orthopedics, anaesthetists, public health etc. The crude ratio of population to doctors is 700:1.

(vi) Home Care Services

(a) Visiting Nurse Organizations - Two organizations, the Victorian Order of Nurses, serving the heavily populated urban area of 85,700 people, and the Saanich Branch of the Greater Victoria Health Board, serving the rural area of 21,000 people, provide home care services to the chronically ill and well known. Saanich nurses provide similar services but in addition to the preventive health work. There are 9 field staff in Victorian Order of Nurses and 12 field staff in Saanich. Both agencies strive to keep the patient independent and in his own home. Victorian Order of





1 Nurses has one nurse specially prepared in reha-  
2 bilitation nursing. Saanich has a part-time  
3 consultant physiotherapist. Victorian Order of  
4 Nurses has a fee for service based on a sliding  
5 scale. Saanich as a public agency provides ser-  
6 vices without charge. Both agencies provide nur-  
7 sing care only on prescription from the patient's  
8 physician. The Victorian Order of Nurses main-  
9 tains a part-time liaison worker in each of the  
10 two large acute hospitals. Referral of patients  
11 on discharge to the visiting nurse agencies is  
12 infrequent. The rehabilitation centre maintains  
13 a contact with the visiting nurse agencies through  
14 case conferences held every alternate week and  
15 refers patients with the approval of the private  
16 physician, as need indicates.

17 (vii) Physiotherapists - An acute shortage exists.

18 The two hospitals have 10, the rehabilitation  
19 centre has 1 physiotherapist and an occupational  
20 therapist. Veterans Hospital has 2, CARS has 1,  
21 Multiple Sclerosis Society has 1 part-time physio-  
22 therapist as has the Saanich Branch of the Greater  
23 Victoria Metropolitan Health Department. There  
24 are 2 in private practise.

25 (viii) Auxiliary Home Care Services

26 (a) The British Columbia Practical Nurses Act of  
27 1951 has not been promulgated and therefore Prac-  
28 tical Nurses have no legal status in the Province  
29 of British Columbia.

30 (b) Nursing aides, nursing assistants and orderlies



Nurses has one nurse specially prepared in rehabilitation nursing. Sannich has a part-time

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case conferences held every alternate week and refers patients with the approval of the private physician, as well as hospital.

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(viii) Auxiliary Home Care Services

(a) The British Columbia Practical Nurses Act of 1951 has not been promulgated and therefore Practical Nurses have no legal status in the Province of British Columbia.

(b) Nursing aides, nursing assistants and orderlies



1 are available in hospitals but are in very short  
2 supply for home care. For example, there are  
3 reported to be 2 orderlies available on a fee  
4 basis ranging from \$4 - \$10, depending on the type  
5 of care needed.

6 (c) Housekeepers - An acute shortage exists,  
7 although certain private agencies as Red Cross  
8 and Silver Threads, maintain a few housekeepers  
9 who are available for short periods on a fee  
10 basis.

11 (d) Meal services for chronically ill and the  
12 aged - No services available.

13 (e) Mental health services including domiciliary  
14 care. There are no local facilities for the  
15 chronically ill and aged.

16 A population of 159,000 has an esti-  
17 mated 26,000 in the 65 years and over age group where  
18 chronic illness is markedly more prevalent than in any  
19 other age group. A large number of individuals and agen-  
20 cies provide a variety of services but there are many un-  
21 met needs and relatively little correlation and coordination.

22 (b) Methods of Improving Existing Services

23 Hospitals - in order to improve health care for the  
24 chronically ill, the Greater Victoria Metropolitan Board  
25 of Health recommends:

- 26 (i) Development of a chronic care wing in each acute  
27 hospital in rural areas - or  
28 Development of chronic care and rehabilitation  
29 hospitals in metropolitan areas to make available:

30 (a) Specialist diagnostic and certain treatment





in hospital but are in very short

supply for home care. For example, there are

beds ranging from \$4 to \$10 depending on the type

of care needed.

also, certain private agencies are not

and others are, and there is a low level of

and are available for short periods on a

it, that need for hospital care is

and - No services needed at

(e) Personal care services provided for the

care. There are no local facilities for the

especially ill and aged.

A population of 100,000 has an esti-

mated 20,000 in the 15 to 24 age group where

control is necessary in the government school

other agencies, a group of 10,000 and again

also provide a variety of services and are very

not needs and potentially little cost and contribution.

Hospitals - in terms of hospital beds, there are

approximately 100, and Greater Victoria Metropolitan Board

of Health recommends:

(1) Development of a clinical care wing in each

hospital in rural areas - or

Development of chronic care and rehabilitation

hospitals in metropolitan areas to make available

(a) Specialist diagnostic and certain treatment



1 facilities for the use of the private physician.

2 (b) Opportunities for research studies.

3 (c) Learning areas in rehabilitation techniques  
4 and attitudes for doctors and nursing staff,  
5 undergraduate students and auxiliary workers.

6 (d) Facilities for the periodic examination and  
7 assessment of patients in private hospitals and  
8 those cared for at home.

9 (ii) Development of out-patient services in connection  
10 with the chronic care wings of acute hospitals  
11 or in rehabilitation hospitals to provide organi-  
12 zed periodic follow-up of the chronically ill  
13 and aged patients.

14 (iii) Development of older persons' Well-being Clinics  
15 under the supervision of the public health  
16 agencies. The most important function of such  
17 clinics to be counselling on preventive health  
18 matters with referral to the private physician  
19 or out patient department where physical examina-  
20 tion or treatment is indicated.

21 (iv) Improvement in the coordination and correlation  
22 of all community health agencies through:

23 (a) Planned education for all on the role and  
24 functions of each. The public health agency to  
25 take the initiative in setting up such planning.

26 (b) Simplification of referral policies.

27 Private Hospitals - The Greater Victoria Metro-  
28 politan Board of Health recommends that:

29 (i) Private hospitals be regarded as a necessary  
30 extension of hospital treatment service and that



Facilities for the use of the private physician.

(c) Opportunity for research studies.

(d) Learning areas in medical education techniques

and attitudes for doctors and nursing staff.

Undergraduate students and military personnel.

(e) Facilities for the periodic examination and

assessment of patients in private hospitals and

those cared for at home.

(ii) Development of co-ordinated services in co-operation

with the chronic care units of acute hospitals

or in general hospital facilities to provide organ

and periodic follow-up of the chronically ill

and aged persons.

Under the supervision of the public health

department. The most important function of such

clinics is to co-ordinate on preventive health

workers with reference to the various diseases

on our public department where physical examina

tion or treatment is indicated.

(iii) Improvement in the coordination and collaboration

of all community health agencies through:

(a) Liaison committee for all on the role and

functions of each. The public health agency to

take the initiative in setting up such planning

and annual revision of referral policies.

Private Hospitals - The Greater Victoria Metro-

politan Board of Health recommends that:

(i) Private hospitals be regarded as a necessary

extension of hospital treatment services and that





1 provision be made for an easy flow of patients  
2 from one type of hospital to another, or to  
3 boarding homes, or to their own homes, as indi-  
4 vidual needs dictate.

5 (ii) That certain of the private hospitals be encour-  
6 aged to provide specialized care for patients  
7 with similar conditions as stroke or orthopedic  
8 conditions. This would be economical of equip-  
9 ment, make better use of trained staff, and thus  
10 make for more skilled care.

11 (iii) That rehabilitation concepts should prevail.

12 Boarding Homes for the Ambulant Chroni-  
13 cally ill and For the Aged The Greater Victoria Metropoli-  
14 tan Board of Health recommends:

15 (1) That an expert committee be set up to recommend  
16 standards and functions of boarding homes based  
17 on the newer concepts of care for the chronically  
18 ill and aged.

19 (ii) That a short course based on the newer concepts  
20 of care for the chronically ill and aged be  
21 developed and made mandatory for operators and  
22 staffs of boarding homes.

23 (iii) That some plan be worked out to provide short  
24 term placements in boarding homes for the chroni-  
25 cally ill or aged who are being cared for at  
26 home. These placements are to provide relief  
27 for relatives for rest or during such family  
28 crises as may arise.

29 Visiting Nurse Services - The Greater  
30 Victoria Metropolitan Board of Health recommends:



one type of hospital is essential, or so

during hours of the day, our work, as in the

which needs to be done.

(ii) Just because of the private hospitals be known

and to provide a creditable service for patients

with special conditions in terms of orthopedic

conditions. This would be essential in order

that, now, the use of private hospitals and that

the use of the same.

(iii) These hospitals should be known to the public.

Self 111 and the City of Victoria Hospital

San Board of Health and the City of Victoria

(iv) and in order to provide a service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

(v) These hospitals should be known to the public

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

and to provide a creditable service for patients

Visiting Nurse Service - The Greater

Victoria Metropolitan Board of Health recommendations



(i) That more use be made of the services presently available to patients in their homes by:

(a) Helping the practising physician become aware of the availability of services given by visiting nurse agencies.

(b) Helping the practising physician become aware of the advantages to the patient of care in his own home.

(ii) That physiotherapists, nutritionists, occupational therapists be added to the staffs of the visiting nurse agencies.

(iii) That hospital services be expanded to cover the provision of ambulances and taxis when ordered by the physician for his chronically ill and aged patients.

(iv) That registered nurses and practical nurses be employed to augment public health nursing staffs.

(v) That learning opportunities be provided for visiting nurses already employed. Priority to be given to rehabilitation techniques, including aids to daily living, and to mental health for the chronically ill and aged.

Housekeeping Services - Practise of the age-old concept that the chronically ill patient and the aged are best cared for in their own homes, means that home services in addition to nursing care services must be provided.

The Greater Victoria Metropolitan Board of Health recommends that: A committee be appointed to study auxiliary services for the nursing care agencies,





(1) That more use be made of the services presently

available to patients in their homes by:

(a) Helping the practicing physician become aware of the availability of services given by visiting

(b) Helping the practicing physician become aware of the advantages to the patient of care in his

(11)

therapists be added to the staff of the visiting

(12) That hospital services be expanded to cover the

provision of substances and tests when ordered by

the physician for his chronically ill and aged

patients.

(13) That registered nurses and practical nurses be

employed to augment existing home nursing staffs

(14) That training opportunities be provided for

visiting nurses already employed. Priority to

be given to rehabilitation techniques, including

side to daily living, and to mental health for

the chronically ill and aged.

Homebased services - Provision of the

age-old concept that the chronically ill patient and the

aged are best cared for in their own homes, means that

home services in addition to nursing care services must be

provided.

The Greater Victoria Metropolitan

Board of Health recommends that: A committee be appointed

to study auxiliary services for the nursing care agencies.



1 particular housekeeping services, and bring in recommenda-  
2 tions. Such services have been studied in a number of areas  
3 including Metropolitan Toronto and the Scandinavian  
4 countries. The study must include ways by which the status  
5 and dignity of a housekeeping service could be increased.

6 Other Auxiliary Services - The Greater  
7 Victoria Metropolitan Board of Health recommends:

8 (i) That legislation be implemented to license  
9 practical nurses and orderlies, and to provide  
10 necessary training and supervision.

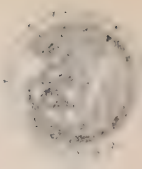
11 (ii) That educational grants be made available to  
12 train these people.

13 (c) Correlation with Existing Agencies

14 All existing health services be co-  
15 ordinated through one central committee. Since the Greater  
16 Victoria Metropolitan Board of Health has appointed the  
17 committee which handles Emergency Health Services for the  
18 area, this agency could also appoint the committee to  
19 coordinate existing and future health services.

20 (d) Provision of Personnel

21 Doctors and Nurses are in good supply  
22 in this area. Considering the favourable climate, nearness  
23 to medical schools and research centres, and the challenge  
24 of rehabilitative medicine, there should be no problem  
25 attracting staff for enlarged programmes. Programmes  
26 should be largely increased. More people sent away for  
27 intensive courses, and more emphasis placed on in-service  
28 education in geriatrics and chronic care. More use should  
29 be made of funds available through National Health Grants  
30 for the further education of medical and para-medical



particular by housekeeping services, and bring in recommendations. Such services have been studied in a number of areas including Metropolitan Toronto and the Scarborough Commission. The study must involve ways by which the status and dignity of a housekeeping service could be increased.

Other Auxiliary Services - The Greater Victoria Metropolitan Board of Health recommends:

(i) That legislation be tabled and to license practical nurses and orderlies, and to provide necessary training and supervision.

(ii) That educational courses be made available to certain home help.

(c) Coordination with Existing Agencies

Let existing health services be coordinated through one central committee. Since the Greater Victoria Metropolitan Board of Health has appointed the committee which handles Emergency Health Services for the area, this agency could also appoint the committee to coordinate existing and future non-physician services.

(d) Revision of Personnel

Doctors and Nurses are in good supply in this area. Considering the favourable climate, however, to medical schools and research centres, and the challenge of rehabilitative medicine, there should be no problem should be largely increased. More people sent away for intensive courses, and more emphasis placed on in-service education in geriatrics and chronic care. More use should be made of funds available through National Health Grants for the further education of medical and para-medical





1 personnel. More emphasis should be placed on rehabilita-  
2 tion and geriatrics in the medical schools and hospital  
3 schools of nursing. The Department of Continuing Medical  
4 Education, University of British Columbia might be able to  
5 give leadership for the teaching of health services per-  
6 sonnel.

7 (e) Present Physical Facilities

8 Both large acute care hospitals are  
9 building additions this year, but these additions allow  
10 only for the present and the immediate future unless  
11 radical changes are made in the area of chronic care.

12 The Greater Victoria Metropolitan  
13 Board of Health recommends that out-patient departments  
14 be added to both large hospitals and to the rehabilitation  
15 centre.

16 In summary the recommendations are:

- 17 1. The concept that public health institutions and  
18 agencies exist as adjuncts of the home be firmly  
19 recognized.
- 20 2. The philosophy of rehabilitation and appropriate  
21 skills be taught all health workers.
- 22 3. Rehabilitating wings be added to acute general hos-  
23 pitals or rehabilitation centres be set up.
- 24 4. Out-patient departments be set up in large acute  
25 care hospitals.
- 26 5. Provision be made for an easy flow of patients from  
27 acute to chronic care hospitals, boarding homes,  
28 private homes and back as the needs of the patient  
29 indicate.
- 30 6. Higher standards be evolved for boarding homes and



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tion and Geriatrics in the medical schools and hospital

schools of nursing. The Department of Geriatric Medical

Education, University of London, should be able to

give leadership for the teaching of health services per-

sonnel.

(c) Preventive Physical Rehabilitation

Both large acute care hospitals and

smaller hospitals should have departments of

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radical changes are made in the area of chronic care.

The Greater Victoria Metropolitan

Board of Health recommends that sub-acute department

be added to both large hospitals and to the rehabilitation

in order to meet the requirements of

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1. The concept that acute and chronic institutions and

agencies exist as segments of the same entity

is not valid.

2. The philosophy of rehabilitation and appropriate

skills be taught and used in hospitals.

3. Rehabilitating wings be added to acute general hos-

pitals or rehabilitation centres be set up.

4. Out-patient departments be set up in large acute

hospitals.

5. Provision be made for an easy flow of patients from

private homes and back as the needs of the patient

indicate.

6. Higher standards be evolved for nursing homes and



provision made for more intensive supervision.

7. Patients in chronic care hospitals and inmates of boarding homes to be re-assessed at regular intervals to insure that the maximum health possible for each individual patient be maintained.

8. Housekeeping and other auxiliary services be increased.

9. Well-being Clinics for the older age group be established.

Thank you.

THE CHAIRMAN: Thank you, Mr. Wyatt.

Mr. Wyatt, on page 3, towards the foot of page 3 and the top of page 4 you refer to private hospitals. It continues on page 7. What is the situation insofar as participating in the Dominion, Provincial Hospitalization Programme? Do these hospitals qualify to be repaid their operating costs under the programme?

MR. WYATT: Mr. Chairman, with your permission I would like Dr. Whitbread to answer any technical or semi-technical questions. He is more conversant with them than I. With your permission may I ask him to answer that question.

THE CHAIRMAN: Dr. Whitbread.

DR. WHITBREAD: Mr. Chairman, the private hospitals do not, as a whole, come under the plan that you outlined. There are five hospitals or institutions that are used in rehabilitation schools, the G. Strong Rehabilitation Centre, Holy Family Hospital, Gorge Road Hospital, the Solarium, and the Pearson Poliomyelitis Centre in Vancouver.

THE CHAIRMAN: None of those five participate?





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THE CHAIRMAN: None of those five



1 DR. WHITBREAD: Those five I mentioned  
2 do participate.

3 THE CHAIRMAN: And the others?

4 DR. WHITBREAD: The others don't  
5 participate.

6 THE CHAIRMAN: They are wholly supported by  
7 fees collected from those who are inmates?

8 DR. WHITBREAD: Yes, sir.

9 THE CHAIRMAN: Dr. Baltzan?

10 COMMISSIONER BALTZAN: Mr. Wyatt,  
11 I have no questions. Thank you for the information regarding  
12 your specific problems.

13 COMMISSIONER GIRARD: Mr. Chairman,  
14 I would like, Dr. Whitbread, some information on page 5,  
15 paragraph 6, where it states the Victorian Order of Nurses  
16 maintains a part-time liaison worker in each of the two  
17 large acute hospitals. Referral of patients on discharge  
18 to the visiting nurse agencies is infrequent. I am a  
19 bit surprised to read this. Does that mean the referral  
20 system is ineffective? You say referrals are infrequent.  
21 We have been led to understand where V.O.N. have a referral  
22 system it was effective in taking patients away from the  
23 hospital beds earlier and putting them in their homes  
24 earlier.

25 DR. WHITBREAD: Mr. Chairman, could I  
26 ask Mrs. Kehr to answer.

27 THE CHAIRMAN: Mrs. Kehr?

28 MRS. KEHR: Mr. Chairman, this reflects  
29 in no way on the liaison service that is being provided  
30 presently by the Victorian Order of Nurses. We appreciate



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ask Mrs. Keir to answer.

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presently by the Victorian Order of Nurses. We appreciate





1 what they are trying to do very much now. Still, the  
2 number of referrals that come through the hospitals is very  
3 small with the exception of the Gorge Road Hospital.

4 COMMISSIONER GIRARD: It isn't effective.  
5 Why is it? Is the nurse visiting the patients and making  
6 them aware of the service they can get going back home?  
7 Why do you think they do not take advantage of this ser-  
8 vice?

9 MRS. KEHR: I don't think the service  
10 is as yet understood by the hospitals, and perhaps by the  
11 medical people of the community.

12 COMMISSIONER GIRARD: I see you state  
13 on page 7 that doctors should be made aware of the services  
14 of the visiting nurse services.

15 MRS. KEHR: Yes.

16 COMMISSIONER GIRARD: That is one of  
17 the reasons you state on the following page. Are there  
18 any other reasons? Could it be, perhaps, that the patients,  
19 if they are in the hospital don't have to pay and if they  
20 have the visiting nurses in their home they would have to  
21 pay the cost of the visit. Would this be one of the  
22 reasons?

23 MRS. KEHR: I couldn't tell you if  
24 that is one of the reasons or not. Half of the area,  
25 approximately half of the population is served by the Saanich  
26 Nurses at no charge at all, and yet I would say one service  
27 is pretty well utilized as much as the other considering  
28 that there is a greater density of chronic care in the  
29 urban area than there is in the rural and suburban areas.  
30 I don't think one could say that is the reason.



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COMMISSIONER GILMAN: I see you state on page 7 that doctors should be made aware of the service of the visiting nurse service.

MRS. KIMM: Yes.

COMMISSIONER GILMAN: That is one of the reasons you state on the following page. Are there any other reasons? Could it be, perhaps, that the patients if they are in the hospital don't have to pay and if they have the visiting nurse in their home they would have to pay the cost of the visit. Would this be one of the reasons?

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that is one of the reasons or not. Half of the area, approximately half of the population is served by the visiting nurses at no charge at all, and yet I would say one service is pretty well utilized as much as the other considering that there is a greater density of chronic care in the urban area than there is in the rural and suburban areas. I don't think one could say that is the reason.



1 COMMISSIONER GIRARD: You have no  
2 point of view of what this reason could be, it is ineffec-  
3 tive. We have been told in other provinces that the  
4 referral system, the V.O.N. referral system were quite  
5 effective in bringing patients out of the hospital earlier.

6 MRS. KEHR: Yes. This is, of course,  
7 a very new service, the V.O.N. liaison service. It means  
8 the nurses are in the hospital for approximately two hours five  
9 days a week and it is quite likely that it is not yet in-  
10 tensive enough.

11 COMMISSIONER GIRARD: Maybe not known  
12 enough.

13 MRS. KEHR: Right.

14 COMMISSIONER GIRARD: I have another  
15 question on page 7, IV: "That registered nurses and prac-  
16 tical nurses be employed to augment public health nursing  
17 staffs." Now, I understood in British Columbia public  
18 health nursing staffs had used auxiliary workers and very  
19 effectively. Do you have anything to add here? I see you  
20 recommend that they be used and we were given to under-  
21 stand that this was the Province where they were being  
22 used, in British Columbia nurses used in public health  
23 nursing.

24 MRS. KEHR: Mr. Chairman, the Victorian  
25 Order of Nurses in Vancouver does use practical nurses,  
26 and I understand find them very satisfactory. Since this  
27 brief was prepared the first practical nurse in the public  
28 health, Provincial Public Health Nursing Service has been  
29 added, and is presently at work.

30 COMMISSIONER GIRARD: Thank you very  
much.





COMMISSIONER GIBBARD: You have no

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COMMISSIONER GIBBARD: Thank you very



1 COMMISSIONER VAN WART: One question,  
2 on page 5, VIII(a): "The British Columbia Practical Nurses  
3 Act of 1951 has not been promulgated and therefore prac-  
4 tical nurses have no legal status in the Province of British  
5 Columbia." Was there any special reason why that Act  
6 wasn't promulgated?

7 DR. WHITBREAD: I have no idea, sir,  
8 why this Act wasn't promulgated.

9 COMMISSIONER VAN WART: Have there been  
10 efforts made to bring it in force since?

11 DR. WHITBREAD: Yes, sir, numerous  
12 efforts.

13 COMMISSIONER VAN WART: Any civic  
14 answer given why it wasn't?

15 DR. WHITBREAD: No, sir.

16 COMMISSIONER VAN WART: That is all,  
17 Mr. Chairman.

18 COMMISSIONER STRACHAN: Mr. Chairman,  
19 referring to paragraph 7 on the first page where reference  
20 is made to school health services, do these health services  
21 include dental services?

22 DR. WHITBREAD: Yes, sir.

23 COMMISSIONER STRACHAN: To what extent?

24 DR. WHITBREAD: Preventive medical  
25 services and there are examinations.

26 COMMISSIONER STRACHAN: Preventive  
27 medical?

28 DR. WHITBREAD: Preventive dental ser-  
29 vices, examination of school children and referral to the  
30 dentist. In the rural areas some treatment is given through



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1 a private dentist.

2 COMMISSIONER STRACHAN: Do I understand  
3 that the children are permitted to attend a private dentist  
4 during school hours?

5 DR. WHITBREAD: Yes, sir.

6 COMMISSIONER STRACHAN: They are?

7 DR. WHITBREAD: Yes, sir.

8 COMMISSIONER STRACHAN: I am sorry,  
9 sir, I have read the other odd brief and it would appear  
10 to the effect they are not permitted to attend a private  
11 dentist during school hours.

12 DR. WHITBREAD: I think it varies.

13 COMMISSIONER STRACHAN: There is a  
14 difference of opinion.

15 DR. WHITBREAD: I think it varies through-  
16 out the Province. In some areas they are permitted to  
17 attend during school hours, in fact, arrangements are made  
18 to have them picked up and taken to the dentist during  
19 school hours.

20 COMMISSIONER STRACHAN: Let us be more  
21 specific. Are they permitted to do so in the City of  
22 Victoria?

23 DR. WHITBREAD: Yes, sir, to the best  
24 of my knowledge they are. Does that answer your question?

25 COMMISSIONER STRACHAN: There is still  
26 doubt in my mind, because a later presentation will submit  
27 otherwise.

28 DR. WHITBREAD: We must correct that  
29 situation, sir.

30 COMMISSIONER STRACHAN: I would hope



2017

Whitbread

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1 you would do so.

2 DR. WHITBREAD: As soon as possible.

3 COMMISSIONER STRACHAN: It is a most  
4 alarming situation. I don't think it is reasonable to  
5 expect a dentist to attend to the dental needs of the  
6 children of a community in before and after school hours.

7 DR. WHITBREAD: I am sorry, Mr. Chair-  
8 man, but I am not able to more definite on this, but I  
9 do know half the area the children are permitted to go through  
10 the schools in the City of Victoria. There may be some  
11 minor rules preventing this. If so, we will look into it  
12 in the future.

13 COMMISSIONER STRACHAN: Who makes the  
14 rules, may I ask?

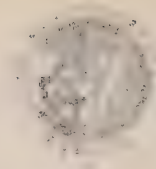
15 DR. WHITBREAD: It is the rule of the  
16 School Board, sir, as far as I know, and depends to some  
17 extent on the opinion of the School Principal.

18 THE CHAIRMAN: Thank you very much,  
19 Mr. Wyatt, Dr. Whitbread, Mrs. Kehr and your associate.  
20 Your brief having been read in its entirety, naturally it  
21 gives us a complete story. We are indebted to you for the  
22 factual information contained in the brief which will be  
23 of value to us and for the recommendations which you have  
24 made. Thank you very much.

25 MR. WYATT: Thank you, Mr. Chairman  
26 and Members of the Commission.

27 THE CHAIRMAN: Dr. Whitbread: This  
28 survey of rehabilitation in Great Britain and Denmark  
29 will go to our research department and has been distributed  
30 to the Members of the Commission.





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1 have been placed in The Victoria and District Dental  
2 Society.

3 THE SECRETARY: The new submission will  
4 be Exhibit 146.

5 ---EXHIBIT NO. 146: Submission of the Victoria and  
6 will not be allowed to the District Dental Society.

7 S U B M I S S I O N O F

8 THE

9 VICTORIA AND DISTRICT DENTAL SOCIETY

10  
11 APPEARANCES:

12 DR. W. G. DEMPSEY

13 DR. C. B. JAMESON

14 DR. W.D. McDUGALL

15 DR. W. W. McLUHAN

16 DR. H. R. TURNER

17 DR. E. N. SCREECH

18  
19 In fact, we are now DR. DEMPSEY: Sir, I am Dr. Dempsey,

20 President of the Victoria District Dental Association. I

21 would like to introduce you to the members of our Committee

22 that have dealt with the Royal Commission on Health. I

23 will start on my immediate far left. Dr. W.W. McLuhan;

24 next Dr. H.R. Turner; next Dr. W.D. McDougall; next Dr.

25 E.N. Screech, Chairman of this group and Dr. C.B. Jameson

26 on my immediate left who will be presenting our brief.

27 THE CHAIRMAN: Dr. Jameson.

28 DR. JAMESON: Mr. Chairman and Members  
29 of the Commission:

30 It is our submission that most dentists



The Victoria and District Dental

Society.

THE SECRETARY. The new submission

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Submission of the Victoria and  
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APPEARANCES:

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THE CHAIRMAN: Dr. Jameson.

DR. JAMESON: Mr. Chairman and Members

It is our submission that most dentists





1 have high ethical standards and the majority are fully  
2 aware of their duties to the public. For this reason the  
3 dentists of this province will welcome any measures which  
4 will improve the dental health of the nation. At the same  
5 time, it is our earnest hope that any future developments  
6 will not be allowed to affect the existing satisfactory  
7 dentist-patient relationship.

8 At the outset, our Society wishes it to  
9 be known that we have complete confidence in Dr. Don W.  
10 Gullett, Secretary of the Canadian Dental Association, in  
11 the administration of any matters pertaining to the practice  
12 of Dentistry in Canada. We endorse the Canadian Dental  
13 Association memorandum presented to the Royal Commission  
14 on Health Services in Ottawa on September 27th, 1961.

15 If I may add here, which is not in our  
16 brief, we intend this particular brief to be a support to  
17 one which will be given to you in the next day or so by  
18 the B.C. Dental Association, and we find no fault in that.  
19 In fact, we endorse it heartily. There is no contention  
20 between the two organizations.

21 In our opinion the following problems  
22 should be considered in any proposed dental policy for  
23 Canadians:

24 (1) PRESENT SITUATION

25 At present, the public in this province  
26 receive their dental treatment from:

- 27 A. Approximately six hundred and seventy dentists in  
28 private practice, on a fee for service basis.  
29 B. Voluntary services are given to some institutions.  
30 e.g. in Victoria,



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Queen Alexandra Solarium

Protestant Orphanage

Silver Threads Service.

The dentists concerned make no charge for their services to these institutions.

The Silver Threads Service was founded by the Victoria and District Dental Society in August 1960, to help aged pensioners of limited means. Laboratory charges to a maximum of fifty dollars per patient are met from British Columbia Dental Association funds, and the dentists give their services without charge in their own offices. In the sixteen months of operation, thirty new dentures have been fabricated and fitted, thirteen either remade or repaired.

C. Seven dentists are employed in the Provincial Department of Health.

D. Seven dental hygienists, working under the direct supervision of dentists.

E. A number of persons with no formal qualifications claiming the title of "Public Denturist".

(2) IMPROVED DENTAL SERVICE COULD BE OBTAINED BY THE FOLLOWING METHODS:

A. Increase in the number of dentists.

Institution of Bursaries and Scholarships to enable suitable candidates to qualify. (A stipulation could be that they practise in areas most in need of dentistry for a period of at least five years, subsequent to graduation.)

B. Post-graduate studies should be an allowable expense for income tax purposes. At present a dentist pays





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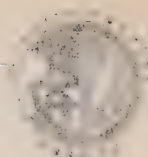
heavy fees for post-graduate courses. Whilst away from his practice, his income ceases, but all expenses continue. This is not an encouragement to improve his standard of skill. The Department of National Revenue rules that a dentist only undertakes post-graduate studies in order that he may increase his income. We submit that this shows a singular lack of understanding regarding a professional man's attitude towards his work.

C. Fluoridation of water supplies to bring them to the level of one part per million where natural fluorine is absent or below this level. (Vide Appendix 1).

APPENDIX 1 - Fluoridation of Water Supplies.

This has been proven to prevent approximately 60% of dental decay in children, while doing absolutely no harm to anyone at this level. Since this is a health measure approved by all Dental and Medical organizations in Canada and the United States of America, the children of British Columbia should receive the benefit of it at once by Provincial legislation, rather than by plebiscites in municipalities and cities, which must depend on the support of an uninformed public. We submit that the Government should take a firm step in this, as it is not a political feature.

D. Dental research should be encouraged and could best be conducted at provincial universities. Similar projects in offices of private practitioners should also receive encouragement.



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1 E. Children should be more readily available during  
2 school hours. (Vide Appendix 2).

3 APPENDIX 2 - School Children. Greater Victoria  
4 School Board.

5 There are approximately 24,000 pupils  
6 in this school area and seventy dentists in practice,  
7 some part-time.

8 An excellent system exists whereby the  
9 dentists employed by the Board examine pre-school  
10 children and those in grades I to XI inclusive.  
11 Those requiring treatment are referred to their  
12 family dentists. So far, so good; but only dental  
13 emergencies and orthodontic cases are allowed leave  
14 of absence after 9:30 a.m. This means that the bulk  
15 of treatment must be carried out after school, and  
16 it is nearly 4 p.m. before a child can reach most  
17 dental offices. Both dentist and patient are tired  
18 at this hour, which is not a happy condition in  
19 which to commence treatment. If one accepts the  
20 premise that the foundations of good dental health  
21 are laid in childhood, this is obviously an unsatis-  
22 factory situation. We maintain that physical health  
23 is a prime requisite for a receptive mind, and think  
24 more consideration should be accorded to us in this  
25 respect.

26 It is not generally appreciated that  
27 dental decay is the world's most prevalent disease.  
28 Almost the entire population is affected by it, and  
29 although its incidence is greater than, say, the  
30 common cold, it is accepted as a normality; or  
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We submit that the Public Schools Act 1958, should be amended to include routine dental treatment as an accepted excuse for leave of absence from school.

F. A Dental Faculty should be established at the University of British Columbia to train:

1. Graduate dentists
2. Dental hygienists
3. Dental technicians
4. Dental assistants

Only fully qualified people should be allowed to perform the operations for which they have been specifically trained. Any Act governing the practice of dentistry should be drawn up in conjunction with the governing body of the dental profession. The latter should decide who are qualified to practise within the limit of their skill. (Vide Appendix 3).

#### APPENDIX 3 Dental Technicians.

In this province, the dental technician situation is chaotic. An example is the recent decision of the British Columbia Legislature to legally register only those technicians to work directly for the public who have been breaking the law for the last seven years, (as laid down under the Dentistry Act of 1936). Up-grading of professional skill can only be attained by raising educational requirements, and not by adulteration and dilution with insufficiently trained personnel. The admission to practice of persons of lesser education will inevitably have the effect of lowering the





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1 prevailing high standards of dentistry. It  
2 degrades the profession in the public eye, and  
3 has an adverse effect on the recruitment of dental  
4 students. Any alteration in the requirements for  
5 the practice of dentistry in this province should  
6 be made in consultation with the Council of the  
7 College of Dental Surgeons of British Columbia, and  
8 not by lay persons who are not cognizant of our  
9 problems.

10 G. It is desirable that PREVENTIVE DENTISTRY receive  
11 priority. Owing to shortage of dentists, any plan  
12 should cover children and be expanded as utilization  
13 of personnel and finances indicate. All proven pre-  
14 ventive methods should be used in this age group,  
15 where the foundations of good dental health can be  
16 laid for life. It has been found that the critical  
17 dental period is between the ages of thirteen and  
18 eighteen, when most treatment is required.

19 (3) GENERAL OBSERVATIONS

20 A Dental Service plan has been prepared by the  
21 British Columbia Dental Association and will be  
22 placed before you in full at Vancouver. We  
23 recommend its adoption in this province. This  
24 plan could be extended to cover the entire popula-  
25 tion, as and when sufficient personnel is available.  
26 If this plan were adopted, we would beg your con-  
27 sideration of the following points:  
28 Owing to lack of personnel (and here is the crux of  
29 the matter) it would be possible to cover only a  
30 small group in the priority classes at first. Money



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1 is not the limiting factor it might appear to be.  
2 If millions of dollars were suddenly made available  
3 for dental treatment, it is doubtful if it would  
4 make any significant difference, as most dentists  
5 are working to capacity already. The dental profes-  
6 sion should be empowered to control any plan to  
7 ensure that children receive prior consideration.  
8 Otherwise an impossible situation will develop.  
9 Without an overall increase in the number of dentists  
10 and ancillary workers, money alone is not the  
11 answer.  
12 This fact has been adequately illustrated in Britain,  
13 where the forcible introduction of a dental health  
14 plan not under direction of the profession resulted  
15 in complete chaos. Up to the time when the Minister  
16 of Health imposed the National Health Service, a  
17 perfectly good and rapidly expanding School Dental  
18 Service was in operation, working in complete  
19 harmony with the remainder of the profession. With-  
20 in a few months it was almost denuded of its staff,  
21 who went into private practice, leaving the classes  
22 where most good could be done without effective  
23 dentistry.  
24 We feel that under the British Columbia Dental  
25 Service Association's plan, a pilot scheme could be  
26 launched at first, confining itself to such numbers  
27 of the priority classes as it could treat, and gra-  
28 dually extending into higher age groups as more  
29 personnel became available.  
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personnel became available.



1 The foregoing observations are submitted with  
2 great sincerity, in the belief that this considera-  
3 tion would benefit the dental health of all  
4 Canadians.

5 THE CHAIRMAN: Thank you, Dr. Jameson.

6 In connection with your fluoridation  
7 situation, what is the legislation in the Province of  
8 British Columbia?

9 DR. JAMESON: I understand that any  
10 change to the water control by a municipality requires a  
11 three-fifths majority vote; that is if fluoridation is to  
12 be instituted in any particular community, it has to have  
13 a three-fifths vote in the affirmative.

14 THE CHAIRMAN: Thank you. And any  
15 municipality may initiate such a vote, or if a municipality  
16 wishes to introduce the fluoridation of the communal water  
17 supply, can it do it without a vote?

18 DR. JAMESON: Sir, if I might ask Dr.  
19 McLuhan, who has studied the subject at some length, to  
20 reply to that.

21 DR. McLUHAN: Mr. Chairman, it requires  
22 a vote in all municipalities in British Columbia, a 60%  
23 majority to enforce it.

24 THE CHAIRMAN: And how many municipali-  
25 ties have fluoridation now?

26 DR. McLUHAN: There are nine at the  
27 present time, sir.

28 THE CHAIRMAN: In the whole of the  
29 Province?

30 DR. McLUHAN: In the whole of the  
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2 ages of population?

3 DR. McLUHAN: Nine municipalities have  
4 a population of 53,000, and the population of the Province  
5 today is 1,600,000.

6 THE CHAIRMAN: You have not reached  
7 into the cities, then?

8 DR. McLUHAN: The largest city will be  
9 Kelowna, with a population of 12,000.

10 THE CHAIRMAN: You have not reached  
11 into the metropolitan area of Vancouver or of Victoria?

12 DR. McLUHAN: No, it was defeated in  
13 Victoria and defeated twice in Vancouver.

14 THE CHAIRMAN: And what was the per-  
15 centage vote obtained in favour or against at that time in  
16 Vancouver, for instance?

17 DR. McLUHAN: Vancouver had a plebis-  
18 cite in 1958, 51% against. And North Vancouver had a per-  
19 centage of 43 against, 43%.

20 THE CHAIRMAN: Victoria?

21 DR. McLUHAN: Victoria was about 60%  
22 against.

23 THE CHAIRMAN: Why?

24 DR. McLUHAN: Sir, we ran across a  
25 great deal of opposition in Victoria, mainly due to the  
26 feelings of a large segment of the elderly people we have  
27 here in Victoria who were given to believe that it would  
28 give them gall-stones, arthritis, cancer, falling arches,  
29 and because of the ---

30 COMMISSIONER McCUTCHEON: House-maid's  
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1 DR. McLuhan: And despite the tremendous  
2 effort of the Victoria Medical Society and the Victoria  
3 Dental Society and other health groups here, we were not  
4 successful.

5 COMMISSIONER STRACHAN: Mr. Chairman,  
6 I am sure we would all like some clarification on this  
7 question of permission to leave the school during school  
8 hours to have dental service.

9 DR. JAMESON: Sir, the situation in  
10 Victoria is that children in the primary grades may be  
11 excused to take dental appointments up until 9:30 a.m.,  
12 up to and including grade VII. That is, they are not  
13 counted absent from school if they receive a certificate  
14 from a dentist that they have been there, and he may make  
15 appointments for them as late as 9:30 a.m. at the very  
16 maximum. That means two school children may be accommodated  
17 at that time of day, and these are the young ones. Unfor-  
18 tunately, these are the younger ones and the ones that  
19 are most urgently in need of treatment are generally the  
20 high school students in, as we mentioned in our brief, the  
21 thirteen to eighteen year-old class when the permanent  
22 teeth, if they are going to be subject to decay, that is  
23 the usual time for the majority of it to happen.

24 These children are not allowed out of  
25 school, with the exception of emergencies, and I am sure  
26 the School Board considers nothing of a toothache an emer-  
27 gency or a broken tooth.

28 This elder group is only allowed to take  
29 dental appointments on Saturdays, or after school. Now,  
30 the school leaving time is approximately 3:30 p.m., and it



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16 maximum. That means two school children may be accommodated

17 at that time of day, and those are the young ones. There-

18 fore, these are the younger ones and the ones that

19 are most urgently in need of treatment are generally the

20 high school students in, as we mentioned in our brief, the

21 thirteen to fifteen year-old class when the permanent

22 teeth, if they are going to be subject to decay, that is

23 the usual time for the majority of it to happen.

24 These children are not allowed out of

25 school, with the exception of emergencies, and I am sure

26 the school board considers nothing of a toothache an emer-

27 gency or a broken tooth.

28 This older group is only allowed to take

29 dental appointments on Saturdays, or after school. Now,

30 the school leaving time is approximately 3:30 p.m., and it



1 generally is not possible for any high school student to  
2 get in before four o'clock to the office.

3                   So that leaves, I would say in the  
4 average office, the time between four o'clock and five-  
5 thirty p.m. inclusive in which this portion of the student  
6 body, which is the portion most urgently requiring treat-  
7 ment and the portion with the greatest amount of treatment  
8 to be seen to.

9                   THE CHAIRMAN: Then, may I ask what  
10 effort has been made to correct the situation? It was  
11 apparently a great surprise to Dr. Whitbread; he was  
12 apparently not aware of it.

13                   DR. JAMESON: Well, this appears to  
14 be under the control of the School Board and more particu-  
15 larly the School Supervisor himself, and there have been  
16 several delegations in the past few years to see if this  
17 could be changed.

18                   Unfortunately, the situation has become  
19 worse and at the time -- up until three years ago, we were  
20 allowed to receive high school students after two o'clock,  
21 which was a great help. However, it was felt by the School  
22 Board and most particularly by the Supervisor of the  
23 Victoria District that this was not necessary.

24                   Particularly we maintained that we  
25 felt dentists were using this time because they could get  
26 their more remunerative patients in during the day and it  
27 was to their financial advantage to get the high school  
28 students in at this time. We had obviously not studied the  
29 statistics on this point, because it is the other way  
30 around, the need is the other way around. However, another





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1 approach was made about six months ago and we have, unfor-  
2 tunately, not been able to make any more headway.

3 COMMISSIONER STRACHAN: I find it  
4 difficult to appreciate the relationship between the various  
5 groups but is it possible, Dr. Whitbread in his capacity  
6 can help you solve this situation?

7 DR. JAMESON: I think it may well be  
8 which will open up a new approach to us, thank you.

9 COMMISSIONER STRACHAN: Some results  
10 may be obtained.

11 DR. SCREECH: I would just like to add  
12 one point there, and that is I understand in the manual  
13 of school law which embraces this Act, that the addition  
14 of two words would alter the whole situation. As it stands  
15 at the present time children are allowed leave of absence  
16 for "necessary medical attention"; if that was changed to  
17 "medical and dental attention" it would cover the whole  
18 situation.

19 THE CHAIRMAN: Dr. Dempsey and gentlemen,  
20 we understand the submission of this brief is ancillary to  
21 the main brief of the British Columbia Dental Association  
22 which we will hear later in the week at Vancouver. We  
23 will, no doubt, at that time have full discussion of dental  
24 problems. The brief now submitted and the information  
25 given will fit in with the further statement and the  
26 further information that we will be receiving in Vancouver.  
27 I want to thank you for your submission.

28 The next submission will be that of  
29 the Canadian Naturopathic Association.

30 THE SECRETARY: This will be Exhibit



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1 ---EXHIBIT NO. 147: Submission of Canadian  
2 Naturopathic Association.

3 APPEARANCES:

4 DR. A. L. RUSSELL

5 DR. J. A. BOUCHER

6 DR. R. M. GRANT

7 DR. R. A. HOLTUM

8 DR. D. J. KIRKBRIDE

9 MR. G. J. SULLIVAN

10  
11 THE CHAIRMAN: Who is the spokesman?

12 DR. KIRKBRIDE: I am, sir. My lord,

13 and commissioners, this afternoon it gives us great pleasure  
14 to be here to present our brief. I would at this time like  
15 to introduce to you members of our delegation. On my  
16 far left is Dr. J.A. Boucher the Secretary of the Canadian  
17 Naturopathic Association. Next to him is Dr. Ronald Grant  
18 from the City of Victoria who is Chairman of our Committee  
19 on Insurance. Next to him is Dr. Ronald Holtum from the  
20 City of Victoria who is presently the President of the  
21 British Columbia Naturopathic Association. Next to him is  
22 Dr. A. L. Russell, past-president of the Canadian Naturo-  
23 pathic Association and several times President of our  
24 British Columbia Association. Then there is our legal  
25 counsel Mr. G.J. Sullivan from the City of Victoria. I am  
26 from the City of Nanaimo and our spokesman for today is  
27 Dr. A. L. Russell.

28 DR. RUSSELL: My lord and members of  
29 the Royal Commission on Health Services: This particular  
30 group represents the Canadian Naturopathic Association



Commission of Canadian  
FEDERAL MOUNTED POLICE

---MONTGOMERY NO. 1447

APPENDIX

DR. A. I. HARRIS

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DR. R. M. GRANT

DR. R. A. HARRIS

DR. A. I. HARRIS

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British Columbia Association. Then there is our legal

counsel Mr. G. J. Sullivan from the City of Victoria. I am

from the City of Winnipeg and our spokesman for today is

Dr. A. I. Russell.

DR. HARRIS: My lord and members of

the Royal Canadian Mounted Police: This particular

group represents the Canadian Naturopathic Association



1 which is speaking for seven other groups in Canada; the  
2 Maritimes, Quebec, Ontario, Manitoba, Saskatchewan, Alberta  
3 and British Columbia. We are speaking for approximately  
4 500 naturopathic physicians in Canada. And now, in the  
5 interest of brevity we would ask the ~~Commission~~ at this  
6 time do you want us to read the brief or take it part by  
7 part, or just take the submissions beginning on page 1 and  
8 then answer questions?

9 THE CHAIRMAN: That is the procedure  
10 we wished to follow, that you deal with your summary and  
11 recommendations and then such further explanation as may  
12 be necessary to elicit any further information on the basis  
13 ~~that the brief~~ has been read.

14 DR. RUSSELL: Thank you. This is a  
15 summary of the main conclusions and recommendations:

16 The Canadian Naturpoathic Association  
17 herewith submits the following recommendations:

18 1. That duly qualified ~~Naturopathic~~ Physicians receive  
19 the full recognition given to members of other estab-  
20 lished practitioners of the healing arts.

21 (Thousands of Canadian citizens will be assured,  
22 thereby, of their right to continue to receive the  
23 services of Naturopathic Physicians as they have in  
24 the past.)

25 2. That the services of Naturopathic Physicians be  
26 available to the public on an equal basis with other  
27 recognized branches of healing. Para. 12-25-26.

28 3. That the present programme of preventive medicine  
29 be broadened.

30 (To increase the present health standards of the  
public.)





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2 and British Columbia. We are speaking for approximately

3 500 naturopathic physicians in Canada. And now, in the

4 interest of novelty we would ask the Commission at this

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19 thereby, of their right to continue to receive the

20 services of naturopathic physicians as they have in

21 the past.)

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23 available to the public on an equal basis with other

24 recognized branches of healing. Para. 12-25-26.

25 That the present programme of preventive medicine

26 be broadened.

27 (To increase the present health standards of the



1 4. That the present stringent rules governing referrals  
2 be made more practical.

3 (To allow closer co-operation between Naturopathic  
4 and Medical professions and thus provide a better  
5 utilization of all existing health services facilities.

6 Para. 27-34-35.

7 5. That promising students in the pursuit of professions  
8 receive full or partial government sponsorship.

9 (This will tend to provide adequate personnel for  
10 all the healing professions to meet future demands.)

11 Para. 32.

12 6. That a comprehensive, government-sponsored health  
13 services programme sufficient to meet, adequately,  
14 the health requirements of all residents of Canada  
15 be established. Para. 39.

16 7. That the health services programme be administered  
17 by a fully representative body of professional and  
18 lay people.

19 (There will be function without prejudice and no one  
20 group nor profession will receive favour to the  
21 exclusion of another.) Para. 44.

22 8. That restrictions and limitations be carefully  
23 studied to avoid any possible form of compulsion.

24 (To insure freedom of choice to the individual of  
25 any recognized, accepted method or means of treat-  
26 ment.) Para. 45.

27 9. That coverage under a national health services pro-  
28 gramme, with certain exceptions (i.e. welfare cases,  
29 etc.) be extended upon a contributory basis.

30 Para. 46-47.



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(There is to be no action without previous and no one

evaluation of another.) Para. 34.

that recommendations and initiatives be carefully

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any recognized, accepted method or means of treat-

ment.) Para. 35.

that coverage under a national health services pro-

etc.) be extended upon a contributory basis.





1 THE CHAIRMAN: Thank you, Dr. Russell.  
2 Could you just tell us what your position in terms of  
3 legislation is in British Columbia?

4 DR. RUSSELL: Yes, sir. Under the  
5 Naturopathic Physicians Act the definition of naturopathy  
6 is:

7 "The art of healing by natural methods  
8 or therapeutics and without limiting the generality  
9 of the foregoing or for the purposes of this Act to  
10 be deemed to include the first-aid treatment of  
11 minor cuts, abrasions and contusions, bandaging and  
12 the taking of blood samples."

13 THE CHAIRMAN: How is the profession  
14 governed in the Province, what is the manner of admission  
15 and discipline and so forth?

16 DR. RUSSELL: The admission to members  
17 of our profession is this, that any man applying must  
18 apply to the Board of Governors the Canadian Naturopathic  
19 Association and he must have two years at a good college  
20 of liberal arts and in addition must have training in a  
21 recognized school of naturopathic medicine of not less than  
22 4,650 hours. After these credentials have been submitted  
23 to the Board they are then covered by the Examination  
24 Committee.

25 THE CHAIRMAN: By whom is the Examina-  
26 tion Committee appointed?

27 DR. RUSSELL: The Examination Committee  
28 is appointed by the Minister of Health and Welfare and it  
29 consists of three members of our Association.

30 THE CHAIRMAN: Does a university



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1 participate in that qualifying examination?

2 DR. RUSSELL: Until two years ago --  
3 three years ago, we had another group associated with our  
4 profession, an advisory group consisting of the then Minister  
5 of Health and Welfare, the then Dean of the Faculty of  
6 Arts and the then Registrar of the University of British  
7 Columbia.

8 THE CHAIRMAN: You refer to the Minister  
9 of Health, you mean Provincial?

10 DR. RUSSELL: Yes. They were an ad-  
11 visory body. As at that time, in 1958, our Act was changed  
12 and they felt we had reached a state of professional  
13 maturity, let us put it that way, that their offices were  
14 no longer required, so on that basis alone we had complete  
15 control of our Act as of now.

16 THE CHAIRMAN: What about your charges,  
17 your service, is that governed by a tariff such as other  
18 professions?

19 DR. RUSSELL: Yes, that is set by the  
20 profession. I might point out, members of our profession  
21 have to pass at least in this Province and some of the  
22 other provinces with an average of 75% and nothing less  
23 than 70. In the Province of Alberta if you are from a  
24 recognized school of naturopathic medicine the Government  
25 will license you without examination.

26 THE CHAIRMAN: Who says which schools  
27 are recognized?

28 DR. RUSSELL: That is set out by the  
29 Canadian Naturopathic Physicians Association and the  
30 Provincial authorities. For instance, in regard to British





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3 then Provincial Secretary, the then Dean of the Faculty of  
4 Arts of U.B.C. and the then Registrar of U.B.C. and they  
5 decided which schools were suitable to meet the requirements  
6 of this Province. I might say the schools that have been  
7 recognized here have in the main, been recognized through-  
8 out Canada.

9 COMMISSIONER FIRESTONE: Dr. Russell,  
10 if I understand you correctly, this brief represents the  
11 views of the Naturopathics all across Canada?

12 DR. RUSSELL: That is right.

13 COMMISSIONER FIRESTONE: It is there-  
14 fore, a national brief?

15 DR. RUSSELL: It is a national brief  
16 and we have the written powers from several associations  
17 giving us the power to represent them.

18 COMMISSIONER FIRESTONE: In paragraph  
19 6 on page 2 you on behalf of your national groups are  
20 recommending a comprehensive government-sponsored health  
21 services program sufficient to meet adequately the health  
22 requirements of all residents of Canada?

23 DR. RUSSELL: Yes, sir.

24 COMMISSIONER FIRESTONE: Now, what you  
25 have in mind here is a comprehensive program instituted  
26 either on a voluntary or a compulsory basis?

27 DR. RUSSELL: As far as this is con-  
28 cerned, we do not presume to be actuaries and we do not  
29 presume to know just the best, as free enterprise members,  
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1 tendency to take the entire nation under their wing and  
2 provide everything for it, but this country was not founded  
3 on that basis. On the other hand, we have to be guided  
4 by whatever situation develops and naturally by what-  
5 ever the powers that be decide, but we are simply placing  
6 it on the basis that it must be comprehensive, that it  
7 takes into consideration all of the people of Canada for  
8 the simple reason that not all people, and this is with  
9 due consideration for the patients of the medical profes-  
10 sion, not all of the people want to go to members of the  
11 medical profession. For instance, while we support the  
12 idea of blood transfusions there are certainly people in  
13 Canada who do not.

14 COMMISSIONER FIRESTONE: I take it,  
15 Dr. Russell, from what you are saying that your primary  
16 concern is that it has to be a comprehensive program and  
17 has to be government-sponsored?

18 DR. RUSSELL: Yes, that is true. The  
19 summation we take at page 10 of the main part of the brief  
20 as to methods of financing:

21 "The obvious advantages of a government-  
22 sponsored national health services programme would  
23 result in:

- 24 1. The provision for complete health
- 25 coverage of all residents of Canada,
- 26 2. The actual cost to the public in
- 27 taxation being less than that now being
- 28 paid out of the public pocket.
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1 system whereby one industry or business  
2 provides better health services and  
3 benefits than another,

4 4. Continuance of coverage in the  
5 event of unemployment or old age,

6 5. Closer control and elimination of  
7 unethical practices."

8 COMMISSIONER FIRESTONE: I take it  
9 those are the reasons why you favour such a program?

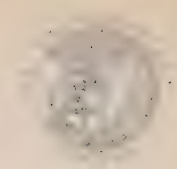
10 DR. RUSSELL: That is right, sir.

11 COMMISSIONER FIRESTONE: And, therefore,  
12 if the program were instituted that would provide these  
13 comprehensive services and were government-sponsored you  
14 would have an open mind as to whether this program in  
15 different provinces would be provided either on a compul-  
16 sory or voluntary basis?

17 DR. RUSSELL: As I understand it, one  
18 of the problems facing this Commission would be the variance  
19 in the laws of each province. In other words, British  
20 Columbia has certain standards and Ontario has others.  
21 The question that seems to appear is whether the Provincial  
22 and Federal Governments can get together on an all-compre-  
23 hensive plan or perhaps would require a changing of the  
24 British North America Act to the extent that the provinces  
25 are willing to delegate certain powers to the Dominion  
26 Government. I do not know.

27 COMMISSIONER FIRESTONE: If I just  
28 pose the questions that you will be able to answer, do I  
29 understand that if the Federal Government were prepared to  
30 support a program that would be Provincially administered





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understand that if the Federal Government were prepared to

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1 and Provincially operated that the Federal Government  
2 make a contribution to such a province and furthermore,  
3 that this program would provide comprehensive services  
4 made available leaving it to each province to decide  
5 whether it may be compulsory or voluntary. Would you  
6 accept such an overall program proposed by the Federal  
7 Government?

8 DR. RUSSELL: We would, sir.

9 COMMISSIONER FIRESTONE: You realize  
10 that your profession is supporting a comprehensive Govern-  
11 ment-sponsored program on a national scale with Provincial  
12 administration and that this recommendation of yours runs  
13 contrary to the recommendations we have been receiving  
14 from the medical profession who have been objecting to a  
15 comprehensive Government-sponsored program. Would you  
16 explain to us why you feel this would be in the interests  
17 of improved health services in your view, even though it  
18 differs from the views held by the members of the medical  
19 profession?

20 DR. RUSSELL: Yes, sir. First of all,  
21 we believe that we have a very efficient civil service in  
22 Canada and also in the various provinces. I am not talking  
23 about the old pork barrel days when members of the civil  
24 service were hired on their ability to get enough support  
25 from one party or another. The fact remains today we have  
26 civil servants throughout Canada that are on an examination  
27 basis, and, therefore, it is assumed they are getting the  
28 best people available for the job. On that basis alone we  
29 feel the Government can provide these services on the most  
30 economical basis and that is a very fundamental thing.

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accept such an overall program proposed by the Federal

COMMISSIONER RINGBOM: You realize

that your proposition is supporting a comprehensive Govern-  
ment sponsored program on a national scale with Provincial  
administration and that this recommendation of yours runs  
contrary to the recommendations we have been receiving  
from the medical profession who have been objecting to a  
comprehensive Government-sponsored program. Would you  
explain to us why you feel this should be in fact interests  
of improved health services in your view, even though it  
differs from the views held by the members of the medical

DR. ROSS: Yes, sir. First of all,

we believe that we have a very efficient civil service in  
Canada and also in the various provinces. I am not talking  
about the old party days when members of the civil  
service were hired on their ability to get enough support  
from one party or another. The fact remains today we have  
civil servants throughout Canada that are on an examination  
basis, and, therefore, it is assumed they are getting the  
best people available for the job. On that basis alone we  
feel the Government can provide these services on the most  
economical basis and that is a very fundamental thing.





1 DOCTOR RUSSELL: The second thing is  
2 this, if you have numerous groups participating in the  
3 plans, if the plan is controlled by one group, I don't  
4 say this is so, there is always the possibility of bias.  
5 Therefore, in order to eliminate any possibilities and  
6 keeping within the democracy, which is in this country,  
7 it is very important to do this.

8 COMMISSIONER FIRESTONE: In Paragraph  
9 7 on page 2 you recommend that the hospital services pro-  
10 gram be administered by a fully representative body of  
11 professional and lay people.

12 DR. RUSSELL: That is right, sir.

13 COMMISSIONER FIRESTONE: Assuming that  
14 the Government were to introduce a comprehensive program  
15 across the country with Provincial Governments participat-  
16 ing in all of the provinces, or the majority of the  
17 provinces, what kind of administrative arrangement do you  
18 visualize? Do you visualize under Paragraph 7 that the  
19 Provincial Governments might set up a Government Commission  
20 to administer such a program with representatives of the  
21 profession and lay people represented on such a commission?

22 DR. RUSSELL: I would suggest that any  
23 health plan of this nature is obviously and basically in-  
24 surance, is it not? Now, any insurance company in dealing  
25 with a person, and I use the broad term, covering all  
26 methods of the healing arts, all groups rather has to have  
27 medical referees. Now, the mechanics of such an insurance  
28 are quite evident. I think you have to determine how the  
29 various billings that have been submitted are to be  
30 processed. Now, obviously it would be very difficult for a



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COMMISSIONER TIERSTON: In Paragraph

Y on page 2 you recommend that the hospital services program be administered by a fully representative body of professionals and lay people.

COMMISSIONER TIERSTON: Assuming that

the Government were to introduce a comprehensive program across the country with Provincial Governments participating in all of the provinces, or the majority of the provinces, what kind of administrative arrangement do you visualize? Do you visualize under Paragraph Y that the Provincial Governments might set up a Government Commission to administer such a program with representatives of the professionals and lay people represented on such a commission? DR. RUSSELL: I would suggest that any

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various things that have been mentioned are to be

processed. Now, obviously it would be very difficult for a



1 medical man to determine if a bill submitted by one of  
2 the other recognized branches of the healing arts, how  
3 they would submit those bills. They would be submitted  
4 to a person qualified to assess them. Therefore, in the  
5 case of the Provincial Government plan they would have to  
6 integrate one or more advisors for the purposes of acting  
7 as referees governing such bills as were submitted to the  
8 public.

9 COMMISSIONER FIRESTONE: I take it  
10 from that first we need an administrative agency, we need  
11 a body that will look after the whole program, not only  
12 the question of billing but the question of budgets,  
13 of standards and many other questions that are related.  
14 Therefore, you need a body to administer. Are you in  
15 favour of a private body or are you in favour of a govern-  
16 ment body set up by the Provincial Government on which  
17 representatives of the profession and the laity is  
18 represented?

19 DR. RUSSELL: The latter.

20 COMMISSIONER FIRESTONE: Thank you  
21 very much.

22 THE CHAIRMAN: You mentioned that any  
23 program is one essentially of insurance.

24 DR. RUSSELL: I beg your pardon?

25 THE CHAIRMAN: You mentioned that you  
26 recognized that any program is essentially one of insurance.

27 DR. RUSSELL: Yes, it is, sir.

28 THE CHAIRMAN: Do you favour the pay-  
29 ment of premiums in advance by users or to have the matter  
30 wholly supported by taxes?





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DR. HIRSHORN: The latter.

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DR. HIRSHORN: I beg your pardon?

THE CHAIRMAN: You mentioned that you

recognized that any program is essentially one of insurance.

DR. HIRSHORN: Yes, it is, sir.

THE CHAIRMAN: Do you favor the pay-

ment of premiums in advance by users or do you favor the

method proposed by Dr. H.



1 DR. RUSSELL: Sir, in the original  
2 submission a few minutes ago I think you will find we don't  
3 feel that we are capable of expressing that.

4 THE CHAIRMAN: In other words, you  
5 have no view to express?

6 DR. RUSSELL: Oh yes, we have, sir.

7 THE CHAIRMAN: That is what I am asking.

8 DR. RUSSELL: Our main view is this,  
9 we believe it should possibly be on a population basis.  
10 The reason of any variance from that view is that we get a  
11 little fed up with the cradle to the grave idea pushed in  
12 this country. That is why we submit the slight alteration  
13 to that idea that it should be completely sponsored by  
14 taxation.

15 THE CHAIRMAN: You wouldn't have the  
16 individual make any direct contribution by way of premium?

17 DR. RUSSELL: This may be in variance  
18 with our brief, but you have asked us to elucidate apart  
19 from that in the manner which we are. I believe the  
20 answer I have given you would cover the situation very  
21 nicely, sir.

22 THE CHAIRMAN: Tax supported and not  
23 premium based?

24 DR. RUSSELL: The premium basis in  
25 British Columbia certainly didn't work. The Government  
26 was pursuing individuals all over the country trying to  
27 collect taxes -- premiums until the present Government  
28 came in. There were, I think, hundreds of thousands of  
29 dollars outstanding. On that basis alone we must have a  
30 central agency, sir. That is our contention. There is



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1 only one variation on that, and that is, however small the  
2 cost to the individual -- the only variation to that, the  
3 psychological effect will improve the relations between  
4 the patient and the practitioner and will tend to stop  
5 abuse of this service.

6 THE CHAIRMAN: What is that?

7 DR. RUSSELL: A small amount taxed on.

8 THE CHAIRMAN: On a co-insurance basis?

9 DR. RUSSELL: Yes.

10 THE CHAIRMAN: What is the small  
11 amount?

12 DR. RUSSELL: There I wouldn't presume  
13 we wouldn't to presume to determine that. We are not  
14 actuaries.

15 THE CHAIRMAN: You will appreciate  
16 it is not an actuarial question. It is a public question.  
17 What will have a good psychological effect on the public.

18 DR. RUSSELL: For example, in British  
19 Columbia we have the \$1.00 a day co-insurance.

20 THE CHAIRMAN: Would you think that  
21 would be a fair co-insurance charge? Is that somewhat in  
22 line with the figure you have in mind?

23 DR. RUSSELL: As far as hospitalization,  
24 sir, I would agree with that.

25 THE CHAIRMAN: I am thinking about  
26 your proposal of comprehensive health services.

27 DR. RUSSELL: Will you give me the  
28 chance to discuss that matter for a moment. I would like  
29 to let Dr. Grant, the Chairman of our group answer that.

30 DR. GRANT: Our point is we feel that



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to let Dr. Grant, the Chairman of our group answer that.

DR. GRANT: Our point is we feel that



1 complete Government-sponsored insurance would lead to  
2 abuse. It would lead to destruction, possibly, as Dr.  
3 Russell said, of the democratic processes. The democratic  
4 process is dependent on the classification of the people  
5 in any Government-sponsored plan. We feel that if contri-  
6 bution can be made by the individual which can be determined  
7 only after the coverage has been set out, what type of  
8 coverage are we going to have, how much is it going to  
9 cost, how much is the Government going to contribute, how  
10 much will the individual contribute. This is excepting  
11 welfare cases. The purpose of it being if you give a man any-  
12 thing for nothing he doesn't appreciate it. He won't do  
13 anything. He won't make any effort. If he is paying an  
14 amount, no matter how small, he will follow instructions  
15 because it is coming out of his pocket.

16                   May I say, if I may digress, they are  
17 not having a lot of the difficulties we are having here in  
18 Great Britain, in spite of what we are told. For example,  
19 we are paying for health services, one individual is paying  
20 on taxes federally, that includes health services, the  
21 various hospitals such as D.V.A. and so on. He pays  
22 again provincially, which includes under the Health and  
23 Welfare Services and hospitals and other medical services.  
24 He again out of his own pocket pays for health coverage  
25 of some type to a commercial insurance firm. There is a  
26 very wide variation of the type of health coverage and the  
27 cost of the coverage. Then he pays again to such worthy  
28 causes, and I believe they are worthy, as the Heart Fund,  
29 the Arthritis Society, the Multiple Sclerosis, TB and Red  
30 Cross, all of which are extremely valuable. I feel all



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only after the coverage has been set out, what type of

coverage we are going to have now which is in going to

case, how much is the government going to contribute, how

much will the individual contribute. This is something

well-known. For instance, if you give a man any-

thing for nothing he doesn't appreciate it. He won't do

anything. He won't make any effort. If he is paying an

amount, he makes his own effort. He will follow instructions

because it is coming out of his pocket.

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not having a lot of the difficulties we are having here in

Great Britain, in spite of what we are told. For example,

we are paying for better services, one individual is paying

on taxes for example, what the other person receives, the

various hospitals such as D.V.A. and so on. He pays

Welfare for the one hospital and other medical services.

He also one of his own pocket pays for health coverage

of which is a very small investment. There is a

very small investment of the type of health coverage and the

cost of the service. Then he pays again to which worthy

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the article is about, the Multiple Sclerosis, TB and Red

Cross, all of which are extremely valuable. I feel all



1 these increase the cost of health to the individual. On  
2 top of that he again contributes, as we in Victoria do,  
3 to the cost of construction of hospitals. This cost is  
4 all coming out of the pocket of the individual. I feel  
5 that perhaps he is paying more for health services in this  
6 manner than he would pay contributing a set amount to a  
7 Government-sponsored plan.

8 THE CHAIRMAN: What do you think the  
9 set amount should be?

10 DR. GRANT: An amount that would be  
11 determined as would any health insurance, the type of cover-  
12 age given costs so much.

13 THE CHAIRMAN: How would he pay this  
14 set amount, through taxes?

15 DR. GRANT: I think through taxes.

16 THE CHAIRMAN: Annually or quarterly?

17 DR. GRANT: I think taxes would be  
18 increased to cover this as we have in British Columbia.  
19 We have a tax on purchases, of course.

20 THE CHAIRMAN: Does your Association  
21 advocate the disbandment of the voluntary agencies such as  
22 you have mentioned?

23 DR. GRANT: I think, yes, because it  
24 means a scattered research, scattered expenditure of money.  
25 The expenditure of collecting money -- professional collec-  
26 tors charge a great deal to do it. I think if all the  
27 money were pooled in one source and all the best brains  
28 were gathered into one place for research I think we would  
29 go further. I believe that the Atom Bomb during the First  
30 World War resulted from just such a thing, that the various



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World War resulted from just such a thing, that the various





1 experts who working separately and in competition  
2 with each other were forced together to pool their know-  
3 ledge and we had it quickly. Any research, any similar  
4 things, any gathering of the best brains and putting them  
5 into one place and supplying them with the necessary funds  
6 instead of having them scattered all over the country is  
7 better, in other words, coalesce brains and coalesce funds.

8 COMMISSIONER BALTZAN: I haven't any  
9 questions. I would like to enlarge my knowledge about two  
10 things.

11 DR. RUSSELL: Yes, sir.

12 COMMISSIONER BALTZAN: Does your prac-  
13 tice of your profession require treating some of your  
14 patients in hospitals?

15 DR. RUSSELL: We have no means availa-  
16 ble to us at the present time.

17 COMMISSIONER BALTZAN: My question is,  
18 does it require?

19 DR. RUSSELL: Yes, that is true.

20 COMMISSIONER BALTZAN: That is all I  
21 wanted to know. Thank you very much. On top of page 7,  
22 Dr. Russell, laboratory X-rays, etcetera must be available  
23 and accessible to all the population. Then it seems you  
24 are in the position you must depend on privately operated  
25 laboratories which are often not located in the immediate  
26 vicinity.

27 DR. RUSSELL: That is right, sir.

28 COMMISSIONER BALTZAN: Are these labor-  
29 atories available to you, these private laboratories?

30 DR. RUSSELL: Yes, sir, they are.



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 10. ...things.

11. DR. RUSSELL: Yes, sir.

12. ...time of your presentation ...  
 13. ...patient in hospital?

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15. ...at the present time.

16. COMMISSIONER BARTMAN: My question is,

17. ...does it ...?

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24. ...laboratories which are often not located in the immediate

25. ...vicinity.

26. DR. RUSSELL: That is right, sir.

27. ...these private laboratories?

28. DR. RUSSELL: Yes, sir, they are.



1 COMMISSIONER BALTZAN: Do these privately  
2 operated laboratories provide you these services?

3 Institute. DR. RUSSELL: Yes, sir, they do.

4 COMMISSIONER BALTZAN: Thank you.

5 DR. RUSSELL: May I elaborate on one  
6 other situation regarding that. We may, within the confines  
7 of our Act have our own laboratories if we so desire. Any  
8 nurses or assistants under our direction may perform any  
9 necessary acts that are conducted in the average laboratory,  
10 blood counts, cholestral counts, all these things.

11 COMMISSIONER STRACHAN: Mr. Chairman,  
12 mention has been made of the qualifications including two  
13 years of the liberal arts. After that you went into  
14 minutes which are rather confusing. Would you translate  
15 that into days, weeks, months or years.

16 DR. RUSSELL: Yes, sir, the qualifica-  
17 tions are four years and nine months. Some schools have  
18 four years eight months. Some schools work on a 50 minute  
19 hour. Some schools work on a 60 minute hour. We have  
20 four years nine months, 60 minute hours, 4500 hours in  
21 total.

22 THE CHAIRMAN: Dr. Van Wart.

23 DR. VAN WART: No questions.

24 THE CHAIRMAN: Thank you very much,  
25 Dr. Kirkbride and gentlemen. Your brief will naturally  
26 be entered into the record and we will give it considera-  
27 tion in due course when the whole matter is being reviewed.

28 We will take a recess for a few  
29 minutes and continue with the brief of the B.C. Women's  
30 Institute.





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THE CHAIRMAN: Dr. Van Wert.

DR. VAN WERT: No questions.

THE CHAIRMAN: Thank you very much.

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be entered into the record and we will give it consideration

tion in due course when the whole matter is being reviewed.

We will take a recess for a few

minutes and continue with the brief of the B.G. Women's

Institute.



1 THE CHAIRMAN: We shall now proceed  
2 with the submission of the British Columbia Women's  
3 Institute.

4 ---EXHIBIT NO. 448: Submission of the British  
5 Columbia Women's Institute.

6 APPEARANCES:

7  
8 MRS. JEAN M. ROBINSON, Chairman of the British  
9 Columbia Women's  
10 Institute

11 MRS. ROBINSON: Mr. Chairman, I am  
12 Jean M. Robinson, Chairman of the British Columbia Women's  
13 Institute and I am speaking on behalf of the British  
14 Columbia Women's Institute.

15 Mr. Chairman, and Members of the Royal  
16 Commission on Health Services, the members of the British  
17 Columbia Women's Institute have welcomed this opportunity  
18 to present a brief at this hearing. It is hoped that our  
19 brief may add something to the sum total of material cover-  
20 ed by your Commission, this should be only a portion of the  
21 benefit to be derived from the task. The conclusions we  
22 have reached as a result of a survey of our membership  
23 would indicate that we of the Women's Institute might well  
24 adopt the slogan "Health is everybody's business", for we  
25 have concluded that all individuals must work to enjoy the  
26 highest possible level of health. We recommend a compre-  
27 hensive program involving the individual. Such a program  
28 must embrace prevention as well as the fact that the  
29 health and safety of the individual is a responsibility of  
30 the individual. We would ask that those in charge of  
health services provide the tools with which the individual



THE CHAIRMAN: We shall now proceed

with the submission of the British Columbia Women's

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---EXHIBIT NO. 446: Submission of the British

APPENDIX 25:

MRS. JEAN M. ROBINSON, Chairman of the British Columbia Women's

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Jean M. Robinson, Chairman of the British Columbia Women's

Institute and I am speaking on behalf of the British

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hensive program involving the individual. Such a program

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1 can maintain himself in the best possible state of  
2 physical, mental and social well-being.

3 To this end, we have included in the  
4 body of our brief various recommendations and suggestions  
5 that we feel would improve our health services. We feel  
6 that these improvements would be of benefit to both the  
7 people of our Province and to those whose task it is to  
8 supervise our health services. We hope that a few of these  
9 recommendations will be new to you; others are included to  
10 add our weight to the recommendations that we know will  
11 be made by other groups and agencies in their specific  
12 fields.

13 We would especially commend the work  
14 of the Mental Health Society, of the Cancer Society, and  
15 of those organizations dealing with the treatment and re-  
16 habilitation of the handicapped.

17 The Women's Institute will watch with  
18 interest the pilot plans that are pioneering the work with  
19 homemaker's services, as well as the public health unit  
20 home nursing service. We would hope to be informed as to  
21 the possibility of extending these services to all parts  
22 of the Province.

23 The Women's Institute is not a service  
24 club or a money-raising organization. Among its objectives  
25 are to improve the conditions of rural health and to promote  
26 home economics, public health, child welfare, education,  
27 and better schools. Anything that we can do to make the  
28 present health services more available to our rural  
29 citizens, or to promote additional services, and to educate  
30 and encourage rural people to make the best use of these



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body of our brief various recommendations and suggestions

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and better schools. Anything that we can do to make the

present health services more available to our people

citizens, or to promote additional services, and to educate

and encourage rural people to make the best use of these



1 services is therefore within the scope of the Women's  
2 Institute.

3 THE CHAIRMAN: Thank you very much,  
4 Mrs. Robinson.

5 COMMISSIONER GIRARD: On page 2, para-  
6 graph 1, Section C, you say:

7 "A more careful screening of those  
8 entering the teaching profession and those already  
9 engaged in teaching to insure that those who are  
10 responsible for so much of the training of our  
11 children are emotionally fit for the task".

12 MRS. ROBINSON: Yes.

13 COMMISSIONER GIRARD: Are you referring  
14 here to a psychiatric examination; or, what are you referr-  
15 ing to?

16 MRS. ROBINSON: Just that people who  
17 are teaching school are fit to teach school, to teach the  
18 children. That they are balanced, and that they like  
19 children.

20 COMMISSIONER GIRARD: Do you have any  
21 ideas of how this screening should take place; what would  
22 you recommend to screen these people?

23 MRS. ROBINSON: I have no exact recom-  
24 mendations, except that if perhaps the schools once a  
25 person gets teaching school, perhaps if the principal or  
26 the school board thinks that a person perhaps needs a  
27 rest for a while, that it would be recommended that they  
28 take one.

29 COMMISSIONER GIRARD: You would leave  
30 it up to the principal of the school?





1 services is therefore within the scope of the Women's

2 Institute.

3

4 Mrs. Robinson.

5 COMMISSIONER GIRARD: On page 2, para-

6 graph 1, Section C, you say:

7 "A more careful screening of those

8 entering the teaching profession and those already

9 engaged in teaching to insure that those who are

10 responsible for so much of the training of our

11 children are emotionally fit for the task".

12 MRS. ROBINSON: Yes.

13 COMMISSIONER GIRARD: Are you referring

14 here to a psychological examination; or, what are you refer-

15 ing to?

16 MRS. ROBINSON: Just that people who

17 are teaching school are fit to teach school, to teach the

18 children, that they are balanced, and that they like

19 COMMISSIONER GIRARD: Do you have any

20 ideas of how this screening should take place; what would

21 you recommend to screen these people?

22 MRS. ROBINSON: I have no exact recom-

23 mendations, except that if perhaps the schools once a

24 person gets teaching school, perhaps if the principal or

25 the school board thinks that a person perhaps needs a

26 rest for a while, that it would be recommended that they

27 it up to the principal of the school?



1 MRS. ROBINSON: Not entirely, no.

2 COMMISSIONER GIRARD: Before a person  
3 starts teaching, it would be the board of education -- or,  
4 if a person has never gone into teaching, and you would  
5 like to be sure this person is emotionally fit for teach-  
6 ing, well then, who would ---?

7 MRS. ROBINSON: In that case, I think  
8 the normal school would investigate their past record.

9 COMMISSIONER GIRARD: And if a person  
10 is in teaching, you think maybe the principal could --?

11 MRS. ROBINSON: Yes, because there are  
12 teachers who get very exhausted after a year or so, and  
13 they no longer like children.

14 COMMISSIONER GIRARD: A medical examina-  
15 tion is that what you would have in mind?

16 MRS. ROBINSON: Yes.

17 COMMISSIONER GIRARD: Then, on the  
18 same page, number 1, paragraph E. I would like to have  
19 you elaborate on this:

20 "Ban the presently popular, but deroga-  
21 tory term "seat warmer" from the jargon of our schools,  
22 and return this unhappy crowd to full citizenship in  
23 our education system".

24 Would you care to elaborate on that?

25 MRS. ROBINSON: Well, I do not know  
26 whether it is a popular term in the rest of the country or  
27 not, but it certainly has been in British Columbia where  
28 I am known best, in lower Vancouver Island. If a boy  
29 particularly is not a good student, as so many boys are  
30 not at grade VI and VII level, they are termed "seat



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1 warmers", and we teach the ones who are keen, ready to go,  
2 but we cannot be bothered so much with a child who needs  
3 to be taught.

4 COMMISSIONER GIRARD: What do you recom-  
5 mend for this category?

6 MRS. ROBINSON: Good teachers who are  
7 interested in those boys particularly.

8 COMMISSIONER GIRARD: You are not think-  
9 ing here of retarded children?

10 MRS. ROBINSON: No, no, I am not think-  
11 ing of the retarded children at all.

12 COMMISSIONER GIRARD: The child who has  
13 a good I.Q., but is not doing well?

14 MRS. ROBINSON: The child who has to  
15 be taught; not the one who is learning on his own.

16 COMMISSIONER GIRARD: This, again, would  
17 be something that should be the function of the normal  
18 school to prepare the teachers for these students?

19 MRS. ROBINSON: Yes, yes.

20 COMMISSIONER GIRARD: I have one more  
21 question.

22 On page 7, paragraph 14, under 2.

23 "That the teaching of first aid be recog-  
24 nized as a highly trained profession and that such  
25 qualified teachers be compensated and recognized on  
26 an equal basis with other qualified instructors".

27 Are you thinking here of the Red Cross,  
28 St. John's Ambulance, who all have courses in first aid  
29 and home nursing?

30 MRS. ROBINSON: Yes.



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27 St. John's Ambulance, who all have courses in first aid

28 and home nursing?



1 COMMISSIONER GIRARD: You are thinking  
2 of them?

3 MRS. ROBINSON: Yes.

4 COMMISSIONER GIRARD: Are you thinking  
5 of any other groups?

6 MRS. ROBINSON: Well, they are the  
7 only two I know, except civil defence, and they use other  
8 instructors, but in this province they get just barely  
9 enough, even industrial first aid....they get barely enough  
10 to cover their expenses.

11 COMMISSIONER GIRARD: You say "be  
12 recognized as a highly trained profession". I think a lot  
13 of people teaching first aid and home nursing for the St.  
14 John's Ambulance and Red Cross are already people in other  
15 professions doing this work as an avocation or part-time?

16 MRS. ROBINSON: Yes.

17 COMMISSIONER GIRARD: Is there some  
18 special recognition you would want them to get?

19 MRS. ROBINSON: They should certainly  
20 get recompense to make it worth their while to work up a  
21 good class.

22 COMMISSIONER GIRARD: Most of it is  
23 done on a voluntary basis?

24 MRS. ROBINSON: Yes, most of it is done  
25 on a voluntary basis.

26 COMMISSIONER GIRARD: Thank you very  
27 much.

28 THE CHAIRMAN: Mrs. Robinson, what is  
29 the distribution of your membership in the Province? Is  
30 it rural and urban, and in what proportion?





COMMISSIONER GIRARD: You are thinking

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MRS. ROBINSON: Yes, most of it is done

on a voluntary basis.

COMMISSIONER GIRARD: Thank you very

much.

THE CHAIRMAN: Mrs. Robinson, what is

the distinction of your membership in the Province? Is

it local and urban, and in what proportion?



1 MRS. ROBINSON: It is practically all  
2 rural. That is what the Women's Institute is. It is for  
3 rural women. There are organizations in the larger dis-  
4 tricts.

5 THE CHAIRMAN: And is it your view  
6 that the Practical Nurses Act should be proclaimed, and ---?

7 MRS. ROBINSON: Yes, sir.

8 THE CHAIRMAN: So that you might have  
9 the benefit of whatever provisions it contains?

10 MRS. ROBINSON: Yes, sir. The Women's  
11 Institute has felt that for a good number of years.

12 THE CHAIRMAN: And as rural women you  
13 see advantages that would come to you from putting into  
14 effect this Act?

15 MRS. ROBINSON: Yes, definitely.

16 THE CHAIRMAN: What is your view, or  
17 of your organization, if you want to express it, on the  
18 matter of paying for the coverage that you support in  
19 paragraph 9 on page 4?

20 MRS. ROBINSON: That medical coverage,  
21 sir?

22 THE CHAIRMAN: Yes?

23 MRS. ROBINSON: The general feeling in  
24 the material I got from the Institute was that people like  
25 to participate -- and not to too great an extent, that they  
26 do like to participate in anything of that kind, and they  
27 feel they are taking a part.

28 THE CHAIRMAN: Is the program that you  
29 would support one which a user would be asked to pay a  
30 premium for?



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1 MRS. ROBINSON: To pay a small  
2 premium, I think.

3 THE CHAIRMAN: Well, for instance, now  
4 in another province there is a suggestion of a plan where  
5 they have a family -- an individual premium of \$12.00, and  
6 a family premium of \$24.00. Now, is that small or large  
7 in the term that you mention?

8 MRS. ROBINSON: In comparison to what  
9 we -- well, it would be very, very small according to what  
10 we are paying now for the health scheme.

11 THE CHAIRMAN: Yes. To get a plan  
12 under M.S.I. or Blue Cross for a family, it is what? In  
13 the neighbourhood of \$110.00 or \$120.00?

14 MRS. ROBINSON: We pay \$125.00.

15 THE CHAIRMAN: \$125.00?

16 MRS. ROBINSON: Yes, it is close to  
17 that, anyway.

18 THE CHAIRMAN: What you had in mind  
19 was something -- a premium lower than that?

20 MRS. ROBINSON: Oh, definitely.

21 THE CHAIRMAN: Was it with the balance  
22 of the cost coming from what source?

23 MRS. ROBINSON: Taxes, I would imagine.

24 THE CHAIRMAN: Now, your Institute,  
25 you say, on page 6:

26 "Regret the unregulated sale of harm-  
27 ful drugs as well as the advertising campaigns put  
28 on to further such sales".

29 And you recommend that something be  
30 done about it?



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THE CHAIRMAN: Well, for instance, now

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they have a family -- an individual premium of \$25.00, and

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in the term that you mentioned?

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we -- well, it would be very, very small according to what

we are paying now for the health scheme.

THE CHAIRMAN: Yes. To get a plan

under M.S.S. or Blue Cross for a family, it is what? In

the neighborhood of \$10.00 or \$15.00?

MRS. ROBINSON: We pay \$125.00.

THE CHAIRMAN: \$125.00?

MRS. ROBINSON: Yes, it is close to

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1 MRS. ROBINSON: Yes.

2 THE CHAIRMAN: Who have you in mind as  
3 the body that should do something about it?

4 MRS. ROBINSON: Well, we recommend all  
5 the way through this report education -- the people them-  
6 selves, at the grass roots. You start in educational cir-  
7 cles.

8 THE CHAIRMAN: Who would put on this  
9 educational program you have in mind?

10 MRS. ROBINSON: The Department of Health.

11 THE CHAIRMAN: Department of Health;  
12 that is a Provincial Department?

13 MRS. ROBINSON: Yes, a Provincial  
14 Department of Health, with the assistance of the Federal  
15 Government.

16 THE CHAIRMAN: I suppose you mean  
17 assistance -- financial assistance?

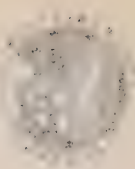
18 MRS. ROBINSON: Yes, I think so.

19 THE CHAIRMAN: What do you think might  
20 be accomplished in terms of this recommendation thirteen?

21 MRS. ROBINSON: Well, I understand that  
22 a good many of our hospital cases at the present time -- the  
23 people who are run in there at night are those--they have  
24 got some sleeping pills beside their bed, and they reach  
25 out and take one; they have a little sleep, they wake up  
26 in ten minutes, and think they haven't been asleep at all,  
27 and they reach out and take another one. Then, they get  
28 too much.

29 THE CHAIRMAN: How do you propose con-  
30 trolling that?





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and they reach out and take another one. Then, they get  
too much.

THE CHAIRMAN: How do you propose con-

tinuing that?



1 MRS. ROBINSON: By education. If they  
2 put half of the energy they are putting into advertising  
3 into an educational program to tell people not to take  
4 too much of these things.

5 THE CHAIRMAN: But that is what you  
6 have in mind? An educational program?

7 MRS. ROBINSON: Yes, an educational  
8 program to go right down to the bottom. "An apple a day  
9 keeps the doctor away", that idea.

10 THE CHAIRMAN: How close -- your  
11 Institute would claim to be a real grass root organization?

12 MRS. ROBINSON: How close are we?

13 THE CHAIRMAN: Yes?

14 MRS. ROBINSON: Let us not say we are  
15 at the bottom, but it is an organization of rural people --  
16 the farmers' wives, miners' wives, loggers' wives. It is  
17 an organization that is made up mostly in the small dis-  
18 tricts. We have a lot of well-educated women, because you  
19 know school teachers and nurses and the like go out into  
20 the rural districts to teach and nurse, and they marry and  
21 settle down there.

22 THE CHAIRMAN: And they remain to be-  
23 come community leaders?

24 MRS. ROBINSON: They remain to become  
25 community leaders, yes, and they start up Women's Institutes  
26 and they are always very anxious to uplift the health level  
27 of their district.

28 THE CHAIRMAN: Now, from that situation,  
29 are you able to give us any information on this point as  
30 to whether there is any group of people in the Province



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are you able to give us any information on this point as

to whether there is any group of people in the Province





1 suffering for want of medical attention?

2 MRS. ROBINSON: I think there are  
3 quite a few that cannot -- they feel they cannot afford  
4 medical attention. It may be pride that is just keeping  
5 them away from the doctor, but I do know there are such  
6 people.

7 THE CHAIRMAN: You think there are a  
8 number of such people?

9 MRS. ROBINSON: Yes, I think there are  
10 quite a few people in their homes who could take chronic  
11 care, or this home nursing, home-maker service. They need  
12 help like that.

13 In our district, just last week a  
14 couple had to go into the hospital because they could not  
15 get anyone to look after them. They were both sick, and  
16 the district nurse went in and did what she could, but it  
17 finally reached the stage that they had to be separated:  
18 One go to one hospital, and the other go into another  
19 hospital.

20 THE CHAIRMAN: You accept the proposi-  
21 tion that if anybody actually goes to the doctor, even  
22 without money, they will receive attention?

23 MRS. ROBINSON: I have never known any-  
24 body who did not.

25 THE CHAIRMAN: But the obstacle, you  
26 think, is an element of pride or independence that would  
27 keep the person away who feels he has not the means to pay?

28 MRS. ROBINSON: They do not want to  
29 burden themselves with an extra debt.

30 I have in mind a family that the husband



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burden themselves with an extra debt.

I have in mind a family that the husband



1 has been told -- he has a wife and five small children  
2 about this high down -- and his wife's medical bills will  
3 be \$2,000.00 to \$3,000.00 a year for the rest of her life,  
4 and he just doesn't know what he is going to do.

5 THE CHAIRMAN: Well, does he not know  
6 that there are agencies of Government and so forth to which  
7 he can go?

8 MRS. ROBINSON: Yes, but it is hard to  
9 go, sir. You have been independent all your life, and it  
10 is pretty hard to knuckle down and go to somebody else and  
11 ask them for help.

12 THE CHAIRMAN: Anything else? Thank  
13 you very much, Mrs. Robinson. We are particularly pleased  
14 that you did come, because we are most anxious to hear  
15 from those whose contact is with a broad representation of  
16 people and of those who are not very vocal in their own  
17 interests.

18 MRS. ROBINSON: Thank you very much.

19 THE CHAIRMAN: The next brief is that  
20 of Dr. P. Beregoff-Gillow.

21

22

23

24

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has been told -- he has a wife and five small children  
about eight high down -- and his wife's medical bills will  
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MRS. ROBINSON: Thank you very much.

THE CHAIRMAN: The next order is that

of Dr. P. Roseberry-Gilman.



S U B M I S S I O N . O F

DR. P. BEREGOFF-GILLOW

THE CHAIRMAN: Yes, Mrs. Beregoff-Gillow?

DR. BEREGOFF-GILLOW: Honorable Sirs:

I congratulate the Royal Commission for granting individuals the opportunity of presenting their ideas on matters of public interest as pertaining to health, on an individual as well as national level. I am convinced the commission will give the content of the Briefs of individuals the same careful consideration and analysis accorded Briefs submitted by large organized groups.

History reveals that progress in every field of human endeavor is a result of the efforts of individuals. Those whose names have been handed down through the centuries, the men and women who contributed to the common good, were hard workers. When their ideas or conclusions differed from the generally-accepted majority viewpoint, these people frequently were subjected to ridicule, open hostility on the part of their colleagues, and sometimes to mob brutality. But they pursued their work with devotion to principles and a passionate regard for truth and for humanity. Honor sometimes came to them posthumously. And in our profession particularly, we have ample evidence that what may be an unorthodox idea or method today, becomes orthodox tomorrow.

The observations and suggestions contained in this Brief are based on 35 years of practice in hospitals and in private practice in three countries. They are offered with the convictions born of experience. If the

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1 language at times may seem emphatic, please forgive. I  
2 have only one purpose in making this presentation - a deep-  
3 rooted desire to help "start the ball rolling" toward a  
4 nationally-directed program aimed at improving health by  
5 prevention of disease rather than waiting until disease  
6 takes over and then trying to effect a cure.

7 1. PREVENTION OF DISEASE:

8 All diseases are due to low resistance.  
9 All are based on constitutional disorders. One in good  
10 health has the recuperative power to resist any type of  
11 invader. That is why, during severe epidemics, about 65  
12 per cent of the population are free of the disease. One  
13 will note too, that these individuals have had little  
14 surgical intervention and little or no medical attention.  
15 It is a known fact that we can breed rats and mice resistant  
16 to disease; cultivate roses resistant to the elements. We  
17 breed champion cattle; we select the best seeds to grow  
18 healthy plants; we select the best fruit trees for grafting;  
19 we select a good soil and feed it properly to obtain maxi-  
20 mum results. If we can do this with animals and plants,  
21 surely we can do it with humans! Dr. Totem, Nobel prize-  
22 winner in physiology, maintains that we can mold desirable  
23 character through breeding. How much more important, the  
24 health one desires!

25 (a) PREGESTATION:

26 I do not advocate mating our youth. I  
27 do advocate, however, that once mated they should be in  
28 perfect health before procreation. It is taken for granted  
29 that two persons are in perfect health when they marry.  
30 Unfortunatley, this is not generally the fact. One or both



I language at times may seem emphatic, please forgive. I have only one purpose in making this presentation - a deep rooted desire to help "start the ball rolling" toward a nationally-directed program aimed at improving health by prevention of disease rather than waiting until disease takes over and then trying to effect a cure.

#### PREVENTION OF DISEASE:

All diseases are due to low resistance. All are based on constitutional disorders. One in good health has the responsive power to resist any type of invasion. For example, during severe epidemics, about 90 per cent of the population are free of the disease. One will note too, that some individuals have had little surgical intervention and little or no medical attention. It is a known fact that we can breed rats and mice resistant to disease; selective roses resistant to the elements. We breed champion cattle; we select the best seeds to grow healthy plants; we select the best fruit trees for grafting; we select a good rolf and feed it properly to obtain maximum results. If we can do this with animals and plants, surely we can do so with humans! Dr. Totem, Nobel prize-winner in physiology, maintains that we can mold desirable character through breeding. How much more important, the health one desires!

#### (c) PRESENTATION:

I do not advocate mating our youth. I do advocate, however, that once mated they should be in perfect health before procreation. It is taken for granted that two persons are in perfect health when they marry. Unfortunately, this is not generally the fact. One or both



1 may have an abnormality, deficiency, or suffer from some  
2 type of infection, latent or acute, which a thorough check-  
3 up may reveal. Timely correction will prevent abnormalities  
4 and deficiencies in the offspring. It is a scientific  
5 fact and has been clinically demonstrated that hormonal  
6 deficiencies corrected in the parents will not appear in  
7 the offspring. I know a family in which there are two  
8 mongoloid children. Both parents were hypothyroids, the  
9 father also was hypopituitary. They were given corrective  
10 treatment for a period of one year, after which the mother  
11 gave birth to a normal child. Undernourished, sickly  
12 mothers are prone to have children lacking resistance to  
13 disease. I therefore advocate that a complete, thorough  
14 checkup (not a "lick and a promise" as is so often done in  
15 our offices) should be mandatory for every couple contem-  
16 plating raising children. They owe it to themselves, their  
17 children, and to society.

18 (b) PREGNANCY:

19 Throughout pregnancy the mother should  
20 undergo periodic checkups. She is the sole provider for  
21 the fetus, responsible for its well-being. She must have a  
22 nourishing, well-balanced diet, supplemented with vitamins  
23 and minerals, and when necessary, hormones. A vacation from  
24 strenuous home duties certainly should be encouraged.  
25 Exercise in the open air will improve circulation, appetite  
26 and morale. Relaxation, pleasant surroundings, a change  
27 of environment have beneficial effects, while stress,  
28 strain, and nervous excitement produce a detrimental effect  
29 on the offspring. The periodic checkups during pregnancy  
30 will reveal or rule out the necessity of surgical inter-





may have an abnormality, deficiency, or suffer from some type of infection, latent or acute, which a thorough check-up may reveal. Timely correction will prevent abnormalities and deficiencies in the offspring. It is a scientific fact and has been clinically demonstrated that hormonal deficiencies corrected in the parents will not appear in the offspring. I know a family in which there are two mongoloid children. Both parents were hypothyroids, the father also was hypothyroid. They were given corrective treatment for a period of one year, after which the mother gave birth to a normal child. Undernourished, sickly mothers are more so have children lacking resistance to disease. I therefore advocate that a complete, thorough check-up for a "little red cross" as it is so often done in our offices, should be mandatory for every couple contemplating raising children. They owe it to themselves, their children, and to society.

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1    vention, including use of forceps during delivery. It is  
2    my conviction that under no circumstances should forceps  
3    be used unless two consultants find it absolutely necessary.  
4    A forceps application not only is injurious to the mother,  
5    but it causes a great systemic shock to the baby, including  
6    possible brain injury. About 98 per cent of mothers can  
7    deliver normally. The act of delivery and the part the  
8    mother can play to eliminate stress should be carefully  
9    explained in advance. And the physician should exercise  
10   a little more patience. Thus, forceps may be avoided.

11           (c) INFANCY:

12                       Shortly after the child is born it  
13   should undergo a thorough checkup. Revealed abnormal  
14   factors then may be gradually corrected. Breast-feeding  
15   should be encouraged. Mothers treated as suggested are  
16   able to provide enough milk. Any mother who can have a  
17   baby, can nurse a baby if properly treated. Gastric up-  
18   sets, allergies and skin disorders will be prevented. The  
19   baby should be in the mother's room so she may watch and  
20   learn how to care for the baby. Under the watchful eye of  
21   the family doctor, the mother can learn the value of  
22   additional nourishment as the child is growing. She can  
23   be taught the importance of supplements such as vitamins,  
24   minerals, amino-acids when necessary; the importance of  
25   fresh air and sunshine, as well as the proper way to clothe  
26   the child. Monthly checkups during the first year, every  
27   two months during the second year, then semi-annually for  
28   the rest of his life will help insure a long, healthful  
29   life.



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(c) Infancy

Immediately after the child is born it  
should undergo a thorough checkup. Revealed abnormal  
should be recognized. Mothers treated as suggested are  
happy and their babies are healthy. The baby is  
happy, and nurse a baby if properly treated. The  
baby should be in the mother's room as the way to teach and  
learn how to care for the baby. Under the watchful eye of  
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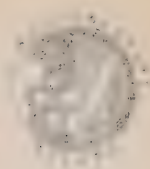
1 (d) RESULT:

2 If both father and mother have received  
3 the same prenatal and postnatal care, if the same precau-  
4 tionary measures are taken by the couple before procrea-  
5 tion, the offspring are bound to be strongly resistant to  
6 disease. This program requires the co-operation of the  
7 medical profession in helping educate the public. By the  
8 same token, the public will have to cooperate whole-hear-  
9 tedly. As this system comes into general use, there will  
10 follow a gradual but definite elimination of mentally  
11 deficient cases, cancer, multiple sclerosis, leukemias,  
12 coronary diseases, arthritis, etc., etc. We can drastical-  
13 ly reduce the number of cripples - physical and mental -  
14 that now fill our institutions!

15 Progress in medicine should mean elimi-  
16 nation of disease, not the building of more and larger  
17 hospitals. It cannot be accomplished overnight. It will  
18 take many, many years. A start, however, can and should  
19 be made now. The time and effort spent in research to find  
20 cures or palliatives, although laudable, is not working in  
21 the right direction. Prevention of disease by treating the  
22 individual instead of the disease, truly is the only  
23 logical method by which a Nation can be made free of  
24 disease.

25 2. PREVENTORIUMS:

26 Preventoriums are outdoor clinics where  
27 the public may obtain periodic complete checkups, treatment  
28 and advice without the necessity of entering a hospital.  
29 At present, our hospitals are filled to capacity, and  
30 about 80 per cent of the cases are non-surgical and could  
have been treated at preventoriums or at home.



(c) RESULTS:

1. Both father and mother have received  
 2. the same prenatal and postnatal care, at the same place -  
 3. Ontario Hospital and taken by the same before process-  
 4. tion, the offspring are found to be strongly resistant to  
 5. disease. This program requires the co-operation of the  
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 26. about 80 per cent of the cases are non-surgical and could



1                                   The preventoriums should be staffed  
2 by fully-qualified physicians, and interns from active  
3 surgical hospitals, in rotation. The clinics should be  
4 provided with complete diagnostic facilities and staffed  
5 by competent technicians. There should be a dietetic  
6 department with a competent dietician to teach the values  
7 of food. It will be necessary to have a pharmaceutical  
8 department as well as a dental department attached to each  
9 preventorium.

10                               Individuals should be fully instructed  
11 before their arrival for a checkup, thus preparing them  
12 for any necessary tests, clinical examinations, X-ray, etc.  
13 Upon completion of the physical examination, supported by  
14 laboratory investigation, the physician should take  
15 sufficient time to explain the findings and not keep them  
16 in ignorance. Should it be found that treatment is neces-  
17 sary, it should be based on the individual's physical con-  
18 dition and not on a stereotyped pattern for the condition.  
19 For no two persons are alike, the physiology of one  
20 differs from another. Particular attention should be paid  
21 to nutrition. By far the greatest percentage of the popu-  
22 lation is ignorant about the value of food and its correct  
23 preparation. People also are ignorant of the detrimental  
24 effects of the irregularity of food intake and the neces-  
25 sity of regular hours of sleep. It is through a proper  
26 diet that we build and protect our resistance to disease.  
27 This is more important than medications, but unfortunately,  
28 the most ignored.

29                               When pathological findings do not indi-  
30 cate surgical intervention, observation and treatment should





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1 be provided at the preventorium or the home under super-  
2 vision of the family physician.

3 3. HOSPITALS

4 Only surgical cases should be admitted  
5 to the hospital, with exception of those medical cases  
6 where home surroundings are not conducive to quick recovery,  
7 and these should enter a convalescent home.

8 CLOSED HOSPITALS should be eliminated.

9 There is no justification of one privileged group of doc-  
10 tors denying hospital facilities to the majority of physicians.

11 Hospitals supported by public funds should be open to  
12 every physician registered to practice medicine. Every  
13 patient should have the privilege of choosing his own  
14 physician. Who but the family doctor could be more inter-  
15 ested in the patient's welfare? Yet, in these closed  
16 hospitals in which a group of "elite" doctors controls  
17 the staff, an intern, not yet registered to practice, pre-  
18 scribes for the patient, while the family doctor cannot,

19 nor dares he, show an interest in the patient. This system  
20 destroys the confidence of the patient in the family doctor,  
21 and when confidence is lacking recovery is retarded. The  
22 reasons given for such practices are that outside doctors  
23 are not as well trained as those of the closed hospital  
24 staff. To me, this is ridiculous! An intern with a few  
25 months' training - is he capable? For argument's sake,  
26 let us assume that the closed hospital philosophy is  
27 correct: If this be true, then the outside doctors should  
28 not be permitted to practice at all, either in their  
29 offices or in the patients' homes! It is a severe indict-  
30 ment of the medical school from which these physicians



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3 8. HOSPITALS

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1 graduated; of the teachers who taught them, and the regis-  
2 tration bodies who allowed them to practice.  
3 The only solution to this problem is the reorganization of  
4 the medical faculties. Hospitals must be opened to every  
5 practising physician. The fact a physician from one closed  
6 hospital cannot treat a patient in another closed hospital  
7 disproves their argument. It is an economic problem,  
8 purely and simply, which must be resolved either by the  
9 medical profession or the Government, interested in the  
10 public welfare. For it is the public that suffers. No  
11 system of medicine should be supported by public funds  
12 unless closed hospitals are eliminated. And there is  
13 one further point - insurance companies should be required  
14 to pay for house or office attention. Many times such  
15 cases should not have to be referred to hospitals at all.  
16 4. PHYSICIANS:

17 We need more physicians. We need the  
18 return of the family doctor. A country never can have too  
19 many doctors! Some provincial medical associations claim,  
20 and especially British Columbia, however, that there are  
21 too many, and raise artificial barriers to prevent physi-  
22 cians entering from other provinces. About 50 years ago  
23 Dr. Roddick proposed an act that every practising physician  
24 in good standing in one province should be allowed to prac-  
25 tise in any other province he might desire, if he believes  
26 the change would benefit not only himself but the community.  
27 Once one has passed the Dominion Council examinations and  
28 is practising in Canada, he should not be required to pass  
29 "Basic Sciences," an examination of no possible value,  
30 regardless of where he obtained his degree. This, too, is



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1 an economic problem which does not work to the advantage  
2 of the community. It is essential that the physician have  
3 a feeling of security in any system of medicine.

4 (a) SPECIALIZATION:

5 Our universities must train men and  
6 women in general medicine. At present, the specialist  
7 learns one part and soon forgets the rest of the body. He  
8 requires a dozen or more consultants to arrive at a precise  
9 diagnosis. Responsibility is divided, and once responsi-  
10 bility goes, the interest goes with it, and the patient is  
11 the victim. The human body must be considered as a whole,  
12 examined by one good doctor, with an occasional consulta-  
13 tion when necessary. Specialization, however, should be  
14 curtailed. The trend to overspecialization is beginning  
15 to make our profession a laughing-stock. We must return  
16 to Osler's teaching - the art of physical examination and  
17 the value of observation. Machines may be capable of aid-  
18 ing in diagnosis but they never will replace the knowledge  
19 obtained by observation. We must treat the individual,  
20 not the disease, thus elevating the recuperative powers  
21 which will help in effecting a cure. Physicians have a  
22 tendency to pay too much attention to pathology, ignoring  
23 to a large extent the importance of the physiology of the  
24 body. In a system of preventive medicine the physician  
25 will be required to know the histology and physiology of  
26 the body in order to keep it in a normal state of health.  
27 People in normal health do not suffer from disease.

28 5. SCHOOLS:

29 Preventive medicine should become an  
30 important subject in our primary schools. Children should





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Preventive medicine should become an

important subject in our primary schools. Children should



1 be taught the value of food, the importance of hygiene and  
2 sanitation, the importance of teeth and their role in the  
3 process of digestion, and the importance of elimination.  
4 It should be presented in a fascinating manner to invoke  
5 interest in the children, our seeds for a healthy nation.  
6 Children often are able to influence parents, and with the  
7 present mode of life, this is most desirable.

8                   Useful adjuncts in educating children  
9 and the general public would be television and radio lec-  
10 tures, carried on as extension work of the schools.

11 6. RESUME:

12                   Prevention of disease may sound like a  
13 very expensive proposition, but I am certain the end result  
14 will be eminently worthwhile, and in the long run, less  
15 expensive than today's method.

16           1. The records would show a substantial decline of  
17           admissions to hospitals and mental institutions.

18           2. Diminished acute illness.

19           3. Decrease in death rate.

20           4. Less absenteeism from work and school.

21           5. Above all, improvement in the general physical  
22           condition of all citizens.

23           6. Cessation in the race for more and larger  
24           hospitals.

25                   It is suggested that this system be  
26 given a trial in some area for a period of 10 years. I am  
27 confident the results, as foretold above, will be achieved.  
28 I know it will work because during 30 years' practice as  
29 described in this Brief, it never was necessary for me to  
30 send a patient to a hospital except for surgery.



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29 described in this Brief, it never was necessary for me to  
30 send a patient to a hospital except for surgery.





1                                Prevention is the only solution to cure  
2 incurable diseases. Establishment of a preventive medicine  
3 program will end the ever-increasing drives for funds to  
4 cure symptoms.

5                                THE CHAIRMAN: Thank you, Miss Beregoff-  
6 Gillow. This is a submission which will receive the due  
7 consideration of the Members of the Commission.

8                                DR. BEREGOFF-GILLOW: Thank you.

9                                THE CHAIRMAN: Dr. Baltzan: Have you  
10 any questions to put to the doctor?

11                               COMMISSIONER BALTZAN: Just one or two,  
12 Doctor, in relation to matters involving the population.  
13 I don't desire to put before you any medical questions.  
14 You state only surgical cases should be admitted to the  
15 hospital with certain exceptions. I ask you is that in  
16 the very best interest of the public, that hospitals should  
17 be confined only to surgical cases?

18                               DR. BEREGOFF-GILLOW: I think it is the  
19 best interest of the public. I think that all medical  
20 cases could be treated at home if the physician would go  
21 to the home instead of dragging the patient to the hospital  
22 for every little thing. I know it as a fact that many  
23 physicians, having been in a hospital for many years, any  
24 little thing that happen, come to hospital, admit to the  
25 hospital, take in patient whether it is necessary or not.  
26 While on Board of Examiners on Vancouver few months ago I  
27 was asked the same question. What would you Dr. Gillow do  
28 if a heart case. I said, a heart case -- what did Osler  
29 do, he said if you have heart case you run to the patient  
30 and you say to him he die in ambulance. He die in the



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Gillow. This is a situation which will involve the in-  
consideration of the Members of the Commission.

DR. BERNARD GILLOW. Thank you.

DR. CHAIRMAN: Dr. Patterson, have you

any questions to put to Dr. Gillow?

COMMISSIONER PATTERSON: Just one or two.

Doctor, in relation to masses involving the population,

I don't desire to put before you any medical questions.

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1 ambulance. 90% of patients who are sent by ambulance to  
2 the hospital with coronary thrombosis die in the ambulance,  
3 but you can save by sending an oxygen tent to their home.  
4 The oxygen tent is at home. What could happen?

5 Another question was asked, what I do  
6 with a diabetes.

7 COMMISSIONER STRACHAN: I didn't ask  
8 that. I asked whether limiting the use of hospitals to  
9 surgical cases was in the best interest of the public. I  
10 didn't ask anything else.

11 DR. BEREGOFF-GILLOW: Yes, it is in the  
12 best interest of the public.

13 COMMISSIONER BALTZAN: You have quoted  
14 an authority, Dr. William Osler as of 1917. Now, there is  
15 one other thing here. You refer to the question of closed  
16 hospitals and then you advocate open hospitals. Listen  
17 carefully to my question. How many acute general hospitals  
18 have you got in Victoria?

19 DR. BEREGOFF-GILLOW: I really, I am  
20 in Victoria only two years.

21 COMMISSIONER BALTZAN: I beg your par-  
22 don, I didn't hear you.

23 DR. BEREGOFF-GILLOW: I am in Victoria  
24 only two years and since I am not allowed to practise here --  
25 I wasn't even permitted to visit hospital or a medical  
26 meeting, if you please, in Victoria.

27 COMMISSIONER BALTZAN: I didn't ask  
28 that.

29 DR. BEREGOFF-GILLOW: So I can't talk.  
30 I can't tell you about Victoria. I can tell you about



10 I can't tell you about Victoria. I can tell you about

29 DR. BURGESS-GILLON: So I can't talk.

28 that.

27 COMMISSIONER BATTMAN: I didn't ask

26 meeting, if you please, in Victoria.

25 I want's even permitted to visit hospital or a medical

24 only two years and since I am not allowed to practice here

23 don't I don't hear you.

22 COMMISSIONER BATTMAN: I beg your pardon.

21 in Victoria only two years.

20 DR. BURGESS-GILLON: I really, I am

19 have you got in Victoria?

18 carefully to my question. How many some general hospital

17 hospitals and also you advocate open hospitals. Listen

16 one other thing here. You refer to the question of closed

15 an authority. Dr. William Osler as of 1917. Now, there is

14 COMMISSIONER BATTMAN: You have quoted

13 best interest of the public.

12 DR. BURGESS-GILLON: Yes, it is in the

11 didn't ask anything else.

10 surgical cases was in the best interest of the public. I

9 that. I asked whether limiting the use of hospitals to

8 with a diabetes.

7 Another question was asked, what I do

6 The oxygen tent is at home. What could happen?

5 but you can safely remain an oxygen tent to their home.

4 the hospital with coronary thrombosis die in the ambulance



1 Montreal.

2 COMMISSIONER BALTZAN: Do you know how  
3 many acute hospitals there are?

4 DR. BEREGOFF-GILLOW: Two acute, two  
5 hospitals.

6 COMMISSIONER BALTZAN: There are only  
7 two. Do you know or can you tell me whether these are  
8 open or closed hospitals?

9 DR. BEREGOFF-GILLOW: I don't know.

10 COMMISSIONER BALTZAN: It would be nice  
11 if you could tell me. Lastly....

12 DR. BEREGOFF-GILLOW: Well, I will tell  
13 you as much as I can about this. If they are open, they  
14 are open in name only, because if you are not on the staff  
15 of the hospital you have to refer the patient. You are  
16 not doctor.

17 COMMISSIONER BALTZAN: It is a closed  
18 hospital.

19 DR. BEREGOFF-GILLOW: Then they are  
20 closed hospitals even they call open.

21 COMMISSIONER BALTZAN: I have heard  
22 from the Victoria Medical Association they have two general  
23 hospitals in Victoria and both of them are open hospitals  
24 and they are not closed hospitals. They have a mental  
25 hospital and they have a further hospital on Queen's Road,  
26 the Queen Alexandra Hospital, a special hospital, I don't  
27 know whether they are closed or not. As far as open hos-  
28 pitals those that are available for general treatment  
29 are open hospitals. The physician, however, has to qualify.

30 Lastly, you say here on the last page:



many acute hospitals there are?

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pitals those that are available for general treatment

are open hospitals. The physician, however, has to qualify

himself, you say here on the last page:





1 "It is suggested that this system be given a trial in  
2 some area for a period of ten years." I suppose you include  
3 preventoriums, preventive medicine, etcetera, etcetera.

4 DR. BEREGOFF-GILLOW: Yes.

5 COMMISSIONER BALTZAN: You have come  
6 from three countries. Have any of these countries given,  
7 had a plan like that we could learn from?

8 DR. BEREGOFF-GILLOW: I couldn't quite  
9 understand you. I am giving this Brief from personal  
10 experience and I know that -- I am not giving any example  
11 of any other country.

12 COMMISSIONER BALTZAN: Please under-  
13 stand we are here to learn, to get information from any  
14 possible source.

15 DR. BEREGOFF-GILLOW: Yes, in Denmark  
16 they have some preventoriums. In Russia, I was at Russia,  
17 they have some preventoriums.

18 COMMISSIONER BALTZAN: They have some  
19 preventoriums?

20 DR. BEREGOFF-GILLOW: Yes, they, of  
21 course, have state medicine, so you know.

22 COMMISSIONER BALTZAN: Can you tell me  
23 for one moment, do you know whether their morbidity or  
24 morality has improved, has it got better than ours here  
25 under the present system? Have you any statistics?

26 DR. BEREGOFF-GILLOW: I couldn't tell  
27 you that. I didn't investigate it. I only know it is  
28 absolutely positive it is bound to improve when you take an  
29 individual before he is sick to find out if there is any-  
30 thing the matter with him in order to prevent illness.



1 "It is suggested that this system be given a trial in  
2 some area for a period of ten years." I suppose you include  
3 preventions, preventive medicine, etcetera.  
4 DR. BERGOTT-GILLOW: Yes.  
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7 had a plan like that we would learn from?  
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9 understand you. I am giving this brief from personal  
10 experience and I know that -- I am not giving any example  
11 of any other country.  
12 COMMISSIONER BALDWIN: Please repeat  
13 stand we are here to learn, to get information from any  
14 possible source  
15 DR. BERGOTT-GILLOW: Yes, in Germany  
16 they have some preventions, to assist, I use at present,  
17 they have some preventions.  
18 COMMISSIONER BALDWIN: They have some  
19  
20 DR. BERGOTT-GILLOW: Yes, they, of  
21 course, have some medicine, as you know.  
22 COMMISSIONER BALDWIN: Can you tell me  
23 for one moment, do you know whether their mortality or  
24 mortality has improved, has it got better than our here  
25 under the present system? Have you any statistics?  
26 DR. BERGOTT-GILLOW: I couldn't tell  
27 you that. I didn't investigate it. I only know it is  
28 absolutely positive it is bound to improve when you take an  
29 individual before he is able to find out if there is any-  
30 thing the matter with him in order to prevent illness.



1 If you have, in any individual -- any one of you that will  
2 come to an office and you are examined and you find you  
3 suffer some deficiency, some abnormality, it is treated  
4 and better before you have illness. Surely you will prevent  
5 sickness.

6 COMMISSIONER BALTZAN: I didn't con-  
7 tinue. Thank you. This is a field I am not at all acquaint-  
8 ed with, I haven't practised this work for quite some  
9 time. It wasn't raised here, but the question of obstet-  
10 rics, do you do that at home?

11 DR. BEREGOFF-GILLOW: I am a diagnos-  
12 tician. I don't do obstetrics.

13 COMMISSIONER BALTZAN: I beg your  
14 pardon?

15 DR. BEREGOFF-GILLOW: I am diagnostician.  
16 I don't do obstetrics.

17 THE CHAIRMAN: Do you feel they can be  
18 done?

19 DR. BEREGOFF-GILLOW: Obstetrics could  
20 be done at home.

21 THE CHAIRMAN: At home?

22 DR. BEREGOFF-GILLOW: Obstetrics.

23 THE CHAIRMAN: Is that implied?

24 DR. BEREGOFF-GILLOW: I believe obste-  
25 trics in normal cases, that is what I say, if the patient  
26 is thoroughly examined and found in every way possible that  
27 no surgical intervention is necessary. It isn't the first  
28 baby or a multiple birth she can be delivered at home or  
29 in a nursing home.

30 THE CHAIRMAN: Is that what you advocate...





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9 time. It wasn't raised here, but the question of obstet-  
10 rics, do you do that at home?

11 DR. BERNGOTT-GILLOW: I am a gynecos-  
12 tician. I don't do obstetrics.  
13 COMMISSIONER BATESMAN: I beg your

14 DR. BERNGOTT-GILLOW: I am a gynecologist.  
15 I don't do obstetrics.

16 THE CHAIRMAN: Do you feel they can be  
17  
18  
19 DR. BERNGOTT-GILLOW: Obstetrics could  
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25 is thoroughly examined and found in every way possible that  
26 no surgical intervention is necessary. It isn't the first  
27 baby or a multiple birth she can be delivered at home or  
28 in a nursing home.

29 THE CHAIRMAN: Is that what you advocate...



1 DR. BEREGOFF-GILLOW: Oh, yes.

2 THE CHAIRMAN: In this paper?

3 DR. BEREGOFF-GILLOW: Yes.

4 THE CHAIRMAN: Thank you very much,  
5 Miss Gillow. This paper will have our consideration in  
6 due course.

7 That completes the last of those who  
8 signified their intention to appear before the Commission.  
9 However, if there is anyone else here who has a submission  
10 to make, we will be glad to hear them. Is there anyone  
11 who has anything further to add to the proceedings today?

12 There being no further submission,  
13 this hearing will be closed insofar as Victoria is con-  
14 cerned and we will resume our hearing tomorrow at ten  
15 o'clock in the Vancouver Hotel at Vancouver.

16  
17 ---Adjournment.  
18  
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30



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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

VANCOUVER

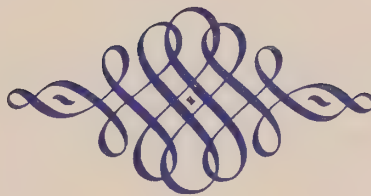
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VOLUME 28

INDEX.

Page No.

THE B.C. DIVISION, CANADIAN  
MEDICAL ASSOCIATION

5977

THE COLLEGE OF DENTAL SURGEONS OF  
BRITISH COLUMBIA AND THE BRITISH  
COLUMBIA DENTAL ASSOCIATION

6099

THE PUBLIC DENTURISTS' SOCIETY OF  
BRITISH COLUMBIA

6143

THE CANADIAN PUBLIC HEALTH ASSOCIATION,  
B.C. DIVISION AND THE CANADIAN INSTI-  
TUTE OF SANITARY INSPECTORS

6155



ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing  
held in Vancouver, British  
Columbia, 20th day of  
February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

U.S. DEPT. OF AGRICULTURE

STANDARD 1.0





Vancouver, British  
Columbia, Tuesday,  
20th February, 1962.

--- On commencing at 10 a.m.

THE CHAIRMAN: Ladies and gentlemen,  
we will come to order and proceed with the hearings  
for the Province of British Columbia, continuing from  
where we left off in Victoria yesterday afternoon.

It is pleasing to see that there are  
many people interested in the work of the Commission  
and the mission it has been asked to perform, and we  
will now have the submission of the Canadian Medical  
Association, British Columbia Division.

--- EXHIBIT NO. 150: Submission of the British Columbia  
Division, Canadian Medical Association.

THE SECRETARY: The Canadian Medical  
Association, B.C. Division, have also filed with us a  
Section of Physical Medicine and Rehabilitation, which  
should be known as Exhibit 150A.

--- EXHIBIT NO. 150A: Section of Physical Medicine and  
Rehabilitation, the British  
Columbia Division, Canadian  
Medical Association.

SUBMISSION OF THE BRITISH COLUMBIA DIVISION,  
CANADIAN MEDICAL ASSOCIATION

Appearances: Dr. H.N. Watson  
Dr. E.C. McCoy  
Dr. E.A.D. Boyd  
Dr. Peter Banks  
Dr. N.J. Blair  
Dr. W.G. McClure



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--- EXHIBIT NO. 150: Submission of the British Columbia Association.

THE SECRETARY: The Canadian Medical

Association, B.C. Division, have also filed with us a section of Physical Medicine and Rehabilitation, which should be known as Exhibit 151.

--- EXHIBIT NO. 151A: Section of Physical Medicine and Rehabilitation, Canadian Medical Association.

COMMISSION OF THE BRITISH COLUMBIA DIVISION  
CANADIAN MEDICAL ASSOCIATION

Dr. E.C. McGoy  
Dr. E.A.D. Boyd  
Dr. J.J. Blair



Appearances (contd)

Dr. Peter Lehman  
Dr. R. Bell-Irving  
Dr. J.F. McCreary  
Mr. W. McCort

DR. WATSON: Miss Girard, Mr. Chairman  
and members of the Commission, I would like to bid you  
a good morning and tell you how much I appreciate the  
opportunity of welcoming you to the mainland here in  
British Columbia. I hope that you will be able to enjoy  
some of our city and our surroundings before you leave.

I would like to apologize for our  
weather. It is the wrong time of year to come here.  
This is a typically blustery winter day here in Vancouver.

I am Dr. Watson, President of the  
Canadian Medical Association, British Columbia Division,  
and I have brought with me a team of my colleagues in  
the Association, the purpose of which is to refer some  
of your questions to them which I feel that I may be  
limited in speaking on or that they may be more facile.

I would like to introduce this team,  
if I could, starting here with Dr. E.C. McCoy, who is  
at the end of the table. He is our Executive Director.  
Next to him, Dr. E.A.D. Boyd, our Executive Secretary.  
Next to me here is Dr. Peter Banks, the Chairman of our  
Medical Economics Committee. Next, Dr. N.J. Blair,  
member of the Executive of the British Columbia Medical.  
Next to him, Dr. W.G. McClure, President-elect of the  
Division. Then, Dr. Peter Lehman, past-President of the  
Association and a practising physician in Vancouver.  
Dr. Robin Bell-Irving, a member of the Executive of the  
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Appearances (cont'd)

Dr. Peter Lehman

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1  
2  
3 of the Faculty of Medicine at the University of British  
4 Columbia. At the end of the table is Mr. W. McCort, a  
5 member of Van Crow Associates, one of the persons who  
6 assisted us a great deal in our public survey.

7 I would like to read to you the  
8 summary and recommendations of our brief. I would like  
9 to point out that we have a revised copy of this which  
10 should be circulated to you. It has only two additional  
11 summaries in it that are attached to one of them. I  
12 will bring this out when I arrive at them. They are  
13 not difficult to fit into the main summary.

#### 14 SUMMARY AND RECOMMENDATIONS

15 1. Whenever the health services of a  
16 country come under review two broad elements are apparent.  
17 The first is the actual health care available, and the  
18 second is the mechanics of the distribution of this  
19 care. These aspects are interdependent.

20 2. The health services and facilities  
21 available to the people of B.C. include all of the modern  
22 medical services that have been developed by science.  
23 Deficiencies do exist in the availability of these  
24 services. Our own history has shown us that services  
25 follow on the heels of need, but we cannot ignore the  
26 fact that at this moment some parts of our province are  
27 far removed from total health facilities. What is  
28 mainly needed is a better correlation of methods of  
29 bringing the people to the services, particularly those  
30 services that are too costly to be established outside  
the metropolitan areas.

3. Hospital facilities for acute care



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### THE HEALTH SERVICES OF A COUNTRY

1. Whenever the health services of a country come under review two broad elements are apparent. The first is the actual health care available, and the second is the mechanics of the distribution of this care. These aspects are interdependent.

2. The health services and facilities available to the people of B.C. include all of the modern medical services that have been developed by science. Deficiencies do exist in the availability of these services. Our own history has shown us that services follow on the heels of need, but we cannot ignore the fact that at this moment some parts of our province are far removed from total health facilities. What is mainly needed is a better correlation of methods of bringing the people to the services, particularly those services that are too costly to be established outside the metropolitan areas.

3. Hospital facilities for acute care





1  
2  
3 of physical illness appear to be adequate in all except  
4 the heavily populated areas. Hospital construction in  
5 B.C. has not always kept pace with need, but the lag  
6 has been less serious in recent years. Facing us today  
7 is a need for about 800 beds for rehabilitative care,  
8 some of which are under construction; 250 additional  
9 beds for acute psychiatric care; and about 600 beds for  
10 acute general hospitals in the metropolitan areas.

11 4. It is important that the programme  
12 of providing beds for Rehabilitative Care be speeded up.  
13 B.C. Hospital Insurance Service has encouraged the  
14 establishment of a number of local units. Progress  
15 depends to a great extent on the initiative of citizen  
16 groups such as hospital societies and municipal councils.  
17 Organization on the local level is needed before new  
18 beds can be financed, and in most communities the medical  
19 society is an active force in this organization.

20 5. Another need, lower in the scale  
21 of priorities, is for facilities for custodial care. No  
22 survey has yet been taken of the number of acute hospital  
23 beds that could be released by moving custodial cases to  
24 the proper facilities where they could be cared for at  
25 lesser cost. This step should be considered following  
26 the Rehabilitation programme, as finances permit.

27 6. Many aspects of health services  
28 offered by the various levels of government are  
29 discussed in detail in the brief. Recommendations below  
30 will reflect our concern that insofar as health care is  
concerned, our native Indians are being treated as  
second class citizens, that the extensive hospital

of physical illness appear to be adequate in all except the heavily populated areas. Hospital construction in B.C. has not always kept pace with need, but the lag has been less serious in recent years. Facing us today is a need for about 800 beds for rehabilitative care, some of which are under construction; 150 additional beds for acute psychiatric care; and about 500 beds for acute general hospitals in the metropolitan areas.

4. It is important that the programme of providing beds for Rehabilitative Care be speeded up. B.C. Hospital Insurance Service has encouraged the establishment of a number of local units. Progress depends to a great extent on the initiative of citizen groups such as hospital societies and municipal councils. Organization on the local level is needed before new beds can be financed, and in most communities the medical society is an active force in this organization.

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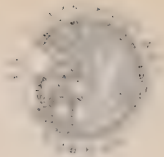


1  
2  
3 facilities of the Department of Veterans' Affairs  
4 should be integrated with community hospitals, and that  
5 in providing health care for all of its charges, the  
6 Government of Canada should eliminate its special provi-  
7 sions, separate and overlapping departments, etc., so  
8 that these people may have the benefits of the same  
9 sources of care available to other citizens.

10 7. Studies by the Canadian Medical  
11 Association indicate the need to concern ourselves with  
12 the future supply of physicians and other health person-  
13 nel, a supply which would appear to depend partly on the  
14 financial ability of young Canadians to undertake long  
15 years of necessary training. Some additional sources  
16 of education subsidy must be found if we are to maintain  
17 what is today a relatively satisfactory supply of doctors  
18 in Canada. The profession of medicine must also remain  
19 attractive to young people in the sense that it is a  
20 free profession - devoid of political control and hospi-  
21 table to new ideas.

22 8. A number of detailed recommendations  
23 have been made below. It is difficult to suggest a  
24 priority between many of them. Who is to say whether it  
25 is more vital to provide complete eye examinations for  
26 pre-school children or to strengthen the laws governing  
27 impaired driving? In common with our colleagues in  
28 other parts of Canada we find it easy to detail the health  
29 needs of the people. Devising ways and means of meeting  
30 those needs is not such a simple task, although in the  
past the medical profession has always met the challenge  
of new health problems as they have been posed. The





facilities of the Department of Veterans' Affairs should be integrated with community hospitals, and that in providing health care for all of its charges, the Government of Canada should eliminate its special provisions for veterans.

that these people may have the benefits of the same sources of care available to other citizens.

#### V. Studies by the Canadian Medical Association

Association indicate the need to concern ourselves with the future supply of physicians and other health personnel, a supply which would appear to depend partly on the financial ability of young Canadians to undertake long years of necessary training. Some additional sources of education subsidy must be found if we are to maintain what is today a relatively satisfactory supply of doctors in Canada. The profession of medicine must also remain attractive to young people in the sense that it is a free profession - devoid of political control and hospitable to new ideas.

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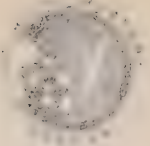
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3 continuing appearance of new health needs tends to  
4 obscure our successes in meeting old ones. However,  
5 in the field of financing personal medical services it  
6 is possible for us to be more specific in our approach.

7 9. The history of organized medicine  
8 in B.C. is a relatively short one compared to the older  
9 provinces of Canada. In less than half a century of  
10 active organization, the medical profession of the pro-  
11 vince has lived in an atmosphere of continuing change;  
12 both in the development of new scientific concepts of  
13 treating disease and in the evolution of economic arrange-  
14 ments governing the provision of health services. The  
15 B.C. Division of the Canadian Medical Association is  
16 accustomed to change, and insofar as the introduction of  
17 methods of meeting the cost of health care is concerned,  
18 we have always offered our leadership.

19 10. We draw your attention to para-  
20 graphs 164 to 250 in our main brief. Summary of this  
21 section without some loss of understanding is difficult.

22 11. There has been a rapid growth of  
23 voluntary prepaid medical insurance in B.C. over the  
24 past two decades. 74% of the B.C. households now enjoy  
25 some degree of prepaid or government-sponsored coverage.  
26 "Comprehensive" coverage is enjoyed by 63% of the house-  
27 holds in B.C.

28 When you have worked in this type of  
29 atmosphere for a while, you find that definitions are  
30 very important. I would like to point out here just  
what we mean by comprehensive, because it is used in  
entirely different ways in various parts of the



continuing appearance of new health needs tends to obscure our successes in meeting old ones. However, in the field of financing personal medical services it is possible for us to be more specific in our approach.

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active organization, the medical profession of the province has lived in an atmosphere of continuing change;

both in the development of new scientific concepts of treating disease and in the evolution of economic arrangements governing the provision of health services. The

B.C. Division of the Canadian Medical Association is accustomed to change, and insofar as the introduction of methods of meeting the cost of health care is concerned, we have always offered our leadership.

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graphs 164 to 250 in our main brief. Summary of this section without some loss of understanding is difficult.

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voluntary prepaid medical insurance in B.C. over the past two decades. 74% of the B.C. households now enjoy some degree of prepaid or government-sponsored coverage. "Comprehensive" coverage is enjoyed by 63% of the households in B.C.

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atmosphere for a while, you find that definitions are very important. I would like to point out here just what we mean by comprehensive, because it is used in entirely different ways in various parts of the





1  
2  
3 discussions.

4 Page 50 of our main brief, we had  
5 stated this: A comprehensive plan in British Columbia  
6 is along these lines that we have put here:

7 "The great majority of medical and  
8 surgical services must be available  
9 to members, the only important exclu-  
10 sions being refractions, routine  
11 check-ups and cosmetic surgery, apart  
12 from those conditions which entitle  
13 the patient to medical care benefits  
14 from the Provincial Government, the  
15 Workmen's Compensation Board or third  
16 party liability insurance.

17 Some short waiting periods are allowed  
18 but in general pre-existing conditions  
19 must be covered. Total limits of  
20 treatment for any one condition must  
21 be so generous as to be rarely appli-  
22 cable".

23 THE CHAIRMAN: That is what you mean  
24 by comprehensive?

25 DR. WATSON: That is our feeling, yes.

26 A small percentage of the population  
27 either has no desire to purchase coverage or intends to  
28 do so but has not done it yet for a variety of reasons.  
29 With prepaid coverage becoming even more widely available  
30 all the time, we find that about 85% of the people of  
B.C. will need no assistance in purchasing good coverage  
when it is available to all.



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discussions.

Page 33 of our main brief, we had

stated this. A comprehensive plan in British Columbia

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"The great majority of medical and

surgical services must be available

to members, the only important exclu-

sions being restrictions, routine

check-ups and cosmetic surgery, apart

from those conditions which entitle

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from the Provincial Government, the

Workmen's Compensation Board or third

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THE CHAIRMAN: That is what you mean

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DR. WATSON: That is our feeling, yes.

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all the time, we find that about 85% of the people of

B.C. will need no assistance in purchasing good coverage

when it is available to all.



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4 12. Who does need assistance? First,  
5 the group already receiving it through our Social Assis-  
6 tance Medical Service. This service for total indigents  
7 should continue but should be confined to them. Second,  
8 the 1961 survey sponsored by the Canadian Medical Associa-  
9 tion - B.C. Division, M.S.A. and M.S.I., two of our  
10 doctor-sponsored prepaid plans, filed before you as an  
11 exhibit, shows that an additional 11.1% of our households  
12 either have an annual income of \$2,000 or less or are  
13 members of a household of five or more persons living on  
14 an annual income of \$3,000 or less.

15 13. If the premiums for this 11.1%  
16 of our population were completely subsidized by public  
17 funds, the cost of providing comprehensive prepaid  
18 medical coverage for the group would only be \$6,480,000.  
19 Partial subsidization, or help on a sliding scale, would  
20 cost even less; in either case a small sum to provide  
21 such assistance, when set against the cost of giving  
22 "free" care to everyone. We suggest that the role of  
23 government is to assist only those who cannot help them-  
24 selves. If this were done, and if prepaid insurance  
25 were purchased by the remaining 12% of the people as it  
26 became available or through our proposed "pooled risk"  
27 plan, B.C. would be in the position of having its popula-  
28 tion fully covered. The only exception would be the two  
29 or three percent who prefer to meet their own medical  
30 expenses as they arise and who certainly should be  
31 allowed to take care of themselves, and those who do not  
32 wish coverage for religious reasons.

33 14. The easy and economical solution



12. Who does need assistance? First,

the group already receiving it through our Social Assistance Medical Service. This service for total indigents should continue but should be confined to them. Second, the 1961 survey sponsored by the Canadian Medical Association - B.C. Division, M.S.A. and M.S.I., two of our

doctor-sponsored prepaid plans, listed below you as an exhibit, shows that an additional 11.1% of our households either have an annual income of \$2,000 or less or are members of a household of five or more persons living on an annual income of \$3,000 or less.

Third, medical assistance

of our population were completely subsidised by public

funds, the cost of providing comprehensive prepaid medical coverage for the group would only be \$6,480,000. Partial subsidisation, or help on a sliding scale, would cost even less; in either case a small sum to provide such assistance, when set against the cost of giving "free" care to everyone. We suggest that the role of government is to assist only those who cannot help themselves. If this were done, and if prepaid insurance were purchased by the remaining 1% of the people as it

became available or through our proposed "pooled risk" plan, B.C. would be in the position of having its population fully covered. The only exception would be the two or three persons who prefer to meet their own medical

expenses as they arise and who certainly should be allowed to take care of themselves, and those who do not wish coverage for religious reasons.

13. The easy and economical solution



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2  
3 to the problem of providing health insurance coverage  
4 for everyone in B.C. who wants such protection involves  
5 two new steps. One, the availability of such coverage  
6 to every citizen with a reasonable premium attached;  
7 and, two, the subsidization of premiums for those who  
8 cannot afford to pay them.

9 15. The number of people with prepaid  
10 health insurance in B.C. has been steadily increasing  
11 and will continue to increase as we make this insurance  
12 available to all. We do not believe that when private  
13 enterprise (in this case non-profit societies) is effi-  
14 ciently providing an essential service that there is any  
15 need for government to take over the job. What is needed  
16 is a degree of government assistance that would mean  
17 that about 85% of the people were sharing the load of  
18 the less fortunate 15%, just as we already share the  
19 costs of providing other essential services for these  
20 people.

21 16. When the question is asked, "How  
22 are the costs of this or that medical service to be met?",  
23 the answer before this Royal Commission often turns out  
24 to be - "Government". Perhaps we should substitute the  
25 word "taxes". We have suggested, or will recommend  
26 below, that "taxes" be used for scholarships for medical  
27 students, to add rehabilitative and chronic care beds to  
28 our hospitals, to extend our mental health programme, and  
29 for many other important services. We feel that tax  
30 money should be directed to these uses as it becomes  
available. Certainly it would seem foolhardy to spend  
taxes on providing a service to those who are already

to the problem of providing health insurance coverage for everyone in B.C. who wants such protection involves two new steps. One, the availability of such coverage to every citizen with a reasonable premium attached; and, two, the subsidization of premiums for those who cannot afford to pay them.

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health insurance in B.C. has been steadily increasing and will continue to increase as we make this insurance available to all. We do not believe that when private enterprises (in this case non-profit societies) are efficiently providing an essential service that there is any need for government to take over the job. What is needed is a degree of government assistance that would mean that about 85% of the people were sharing the load of the less fortunate 15%, just as we already share the costs of providing other essential services for these people.

16. When the question is asked, "How

are the costs of this or that medical service to be met?" the answer before this Royal Commission often turns out to be - "Government". Perhaps we should substitute the word "taxes". We have suggested, or will recommend below, that "taxes" be used for scholarships for medical students, to subsidize investigative and chronic care beds to our hospitals, to extend our mental health programme, and for many other important services. We feel that tax money should be directed to these uses as it becomes available. Generally it would seem foolhardy to spend taxes on providing a service to those who are already





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2  
3 providing it for themselves, as most British Columbians  
4 are doing through our system of voluntary health insurance.

5 17. There will never be unlimited  
6 funds in Canada for health care. The problem will  
7 always be one of priorities. The need in B.C. today is  
8 for additional facilities and for increased aid to medi-  
9 cal education. Above all, there is a need to use a  
10 small portion of our taxes to pay for the personal  
11 medical care of those who cannot afford it, and to do  
12 this by paying the necessary part of their premiums  
13 into a voluntary insurance plan. What health funds are  
14 available beyond this should be used where the needs  
15 are greatest.

16 RECOMMENDATIONS

17 The following are general statements  
18 of the more important recommendations arising out of  
19 the main Brief, with the appropriate paragraphs of the  
20 main Brief noted in each case. A more detailed discus-  
21 sion of each recommendation is set forth in the para-  
22 graphs indicated.

23 1. That voluntary prepaid health  
24 insurance be recognized as the system best suited to  
25 the needs of British Columbia (paragraphs 214-221, 244-  
26 248, 281); that premiums for those who cannot afford  
27 them be paid from public funds, and be paid as premiums  
28 to one or more of the existing voluntary plans (para-  
29 graphs 202-208, 223-230); and that the number and  
30 variety of voluntary plans operating in B.C. be encouraged  
both as a competitive control measure and as a means of  
making differing degrees and types of insurance available



providing it for themselves, as most British Columbians  
are doing through our system of voluntary health insurance.  
17. There will never be a situation

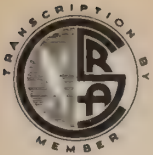
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for additional facilities and for increased aid to volun-  
tal education. Above all, there is a need to use a  
small portion of our taxes to pay for the medical  
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into a voluntary insurance plan. That health funds are  
available beyond what should be used where the need  
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### RECOMMENDATIONS

The following are general statements  
of the more important recommendations arising out of  
the main study, with the appropriate paragraphs of the  
main report noted in each case. A more detailed discus-  
sion of each recommendation is set forth in the particu-

### RECOMMENDATIONS

1. That voluntary health insurance  
insurance be recognized as the system best suited to  
the needs of British Columbia. (Paragraphs 1-10, 24-25,  
26, 28, 29; that premiums for those who cannot afford  
them be paid from public funds, and be paid as premiums  
to one or more of the existing voluntary plans (para-  
graphs 26-28, 29-30, 31-32); and that the present and  
variety of voluntary plans operating in B.C. be encouraged  
both as a constructive control measure and as a means of  
making ordering devices and types of insurance available



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3 to all (paragraphs 249-250).

4 2. That facilities for the treatment  
5 of acute mental illness be distributed throughout the  
6 province; that persons suffering from acute mental  
7 illness be considered in the same light as those with  
8 any other acute condition; and that all mental health  
9 efforts in the community be co-ordinated in the interests  
10 of effective and economical results (paragraphs 61-71).

11 3. That greater financial assistance  
12 be granted to medical students, possibly through the  
13 means of additional scholarships from public funds  
14 (paragraphs 128-139); and that means also be found to  
15 encourage the future supply of highly skilled lay health  
workers (paragraphs 155-163).

16 4. That the Federal and Provincial  
17 Governments should finance an independent Board of  
18 Administrative Research, composed of representatives  
19 from government, university and the medical profession;  
20 that the services of this board be available to all on  
21 an advisory basis, for the purpose of studying and  
22 making recommendations concerning such matters as  
23 unnecessary duplication of health services, common  
24 plans for hospital construction, co-operation between  
25 voluntary health agencies and government departments,  
26 provision of up-to-date health statistics, etc. (Para-  
27 graphs 108-110).

28 5. That the Federal Government should  
29 provide for one standard of care for its charges  
30 (Indians, Veterans, Sick Mariners, etc.); and that this  
should be the community standard, using the general







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3 community health facilities (paragraphs 103-105).

4 6. That the programme for rehabilita-  
5 tive hospital beds, as undertaken by B.C.H.I.S., be  
6 carried out with all possible speed; and that as a later  
7 step the two senior governments be urged to co-operate  
8 in a programme to provide special facilities for custo-  
9 dial care (paragraphs 50-55).

10 6A. Comprehensive physical medicine  
11 and rehabilitation departments should be established in  
12 community hospitals or groups of hospitals with approxi-  
13 mately five hundred beds. These departments should be  
14 directed by specialists of physical medicine and rehabili-  
15 tation. Each unit should have an activation ward of not  
16 less than twenty beds. Both in-patient and out-patient  
17 services should be provided. This programme should be  
18 established by an extension of the present B.C. Hospital  
Insurance Service.

19 6B. The responsibility for the  
20 continuing care of patients treated in these units should  
21 belong to the family doctor, assisted as necessary by  
appropriate specialists.

22 7. That an organized ambulance service  
23 be provided from public funds for the transportation of  
24 serious cases to the larger hospitals in the province  
(paragraphs 35-36).

25 In summarizing this we have lost a  
26 bit of the meaning but I would say we mean by this that  
27 this service should be rendered from a distance. In  
28 other words, this should be rendered from portions of  
29 the province distant from hospitals.  
30

community health facilities (paragraphs 14-15).

6. When the Government for the first-

tive hospital beds, as was done by R.C.H.I.S., be  
comprehend that all medical staffs and that as a  
step the two senior governments be urged to co-operate  
in a programme to provide a better facilities for  
dial care (paragraphs 16-17).

7. When the Government for the first-

and medical staffs should be established in  
community hospitals or groups of hospitals with a  
mately five hundred beds. These departments should be

directed by specialists of private medicine and health-  
tation. Each unit should have an activation ward of not  
less than twenty beds, both for patient and out-patient  
services should be provided. This programme should be

established by an extension of the present R.C.H.I.S. hospital  
Insular Services.

8. The responsibility for the

continuation of care of patients and in their return  
belong to the family doctor, assisted as necessary by

9. That an organized programme service

be provided for the first time for the provision of  
serious cases to the larger hospitals in the province.

10. In order to bring this to pass, a

list of the names of the hospitals should be made by this  
this service should be rendered from a distance in  
other words, this should be rendered from portions of  
the province distant from hospitals.





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3 THE CHAIRMAN: Are you talking of air  
4 ambulance there?

5 DR. WATSON: All kinds. In our main  
6 brief it is pointed out that about three-quarters of  
7 the population of British Columbia would not really need  
8 this service because they are in the lower mainland or  
9 the Victoria area but one-quarter are in areas where  
10 this would be very helpful and essential.

11 8. That all hospitals be open hospi-  
12 tals, with the exception of any hospital primarily  
13 intended for teaching or research purposes (paragraphs  
14 42-44, 98-99).

15 9. That the Health Branch of the B.C.  
16 Government should establish a Virology Service (para-  
17 graph 60); that the B.C. Hospital Insurance Service  
18 should provide additional isotope diagnostic centres  
19 throughout B.C. (paragraph 79); and that a Central  
20 Reference Laboratory should be established by the Health  
21 Branch (paragraph 80).

22 10. That the Department of Education  
23 be asked to include fuller courses in basic human physio-  
24 logy in the high school curriculum (paragraphs 276, 277).

25 11. That the "Budget Formula" be  
26 accepted as the method for payment of hospital Patholo-  
27 gists (paragraphs 77, 81, 158), and that hospital Radio-  
28 logists be paid on some type of fee-for-service basis  
29 (paragraph 72). The private practice of Radiology and  
30 Pathology should continue (paragraphs 73, 78).

12. That more funds be directed by  
the Federal Government into medical research (paragraph

THE CHAIRMAN: Are you talking of air

brief it is pointed out that about three-quarters of the population of British Columbia would not really need this service because they are in the lower rainfall or the Victoria area but one-quarter are in areas where this would be very helpful and essential.

8. That all hospitals be cost hospi-

tals, with the exception of any hospital primarily intended for teaching or research purposes (paragraphs

9. That the Health Branch of the B.C.

Government should establish a clinical service (para-

graph 10); that the B.C. Hospital Insurance Service

should provide additional diagnostic services

throughout B.C. (paragraph 11); and that a Central

Reference Laboratory should be established by the Health

Branch (paragraph 12).

10. That the Department of Education

be asked to include further courses in basic human physio-

logy in the high school curriculum (paragraphs 13, 14, 15).

11. That the "Budget Form" be

accepted as the method for payment of hospital patron-

ists (paragraphs 16, 17, 18), and that hospital Radio-

logists be paid on some type of fee-for-service basis

(paragraph 19). The private practice of Radiology and

Radiology should continue (paragraphs 20, 21).

12. That more funds be directed by

the Federal Government into medical research (paragraph



267).

This is not just research as to disease but it is far-reaching into medical education as far as we see it.

13. That income tax relief be given to those doctors who attend post-graduate studies (short or long courses) as part of keeping abreast of their work (paragraphs 144-147).

14. That the Food and Drug Directorate of the Federal Government be given increased finances in order that it may control the quality and reliability of all drugs sold in Canada and tighten controls on advertisements of proprietary medicines (paragraphs 257, 272).

I would like to draw your attention to the fact that in our main brief there is a diagram following the yellow section which shows in a factual way the medical coverage in British Columbia. Thank you, Mr. Chairman.

THE CHAIRMAN: Do any of those with you wish to amplify or make any further statement at this time?

DR. WATSON: No, I do not believe so.

THE CHAIRMAN: Dr. Watson, perhaps Dr. McCreary may wish to deal with this subject but you appear to lay some stress on what you refer to in your summary, page 6, No. 8, that all hospitals be open hospitals. Are you advocating a change here or what is the situation in British Columbia at the moment?

DR. WATSON: We are advocating a great



This is not just research as to disease but it is far-reaching into medical education as far as we see it.

15. That income tax relief be given to those doctors who attend post-graduate studies (grant on long term) in part of keeping records of their work (paragraphs 14-15).

16. That the Food and Drug Administration of the Federal Government be given increased powers in order that it may control the quality and reliability of all drugs sold in Canada and tighter controls on advertisement of proprietary medicines (paragraphs 16-17).

288.

I would like to draw your attention to the fact that in our white paper there is a chapter following the yellow section which shows in a graphic way the national coverage in British Columbia. Thank you.

The C.I.B.A. is one of those with you when to finally or make any further statement at this time.

WATSON: No, I do not believe so.

McGarry may wish to deal with this subject but you appear to have some ideas on what you refer to in your summary, page 6, Vol. 2, that all hospitals be open hospitals. And you advocating a change here or what is the situation in British Columbia at the moment?



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3 change. The only hospitals in British Columbia that  
4 are closed hospitals, as you call them, would be ones  
5 under the jurisdiction of the Federal Government such  
6 as D.V.A. or the Indian hospitals. Dr. McCreary may  
7 expand on this.

8 DR. MCCREARY: Mr. Chairman, we in  
9 British Columbia are favoured in this regard that every  
10 doctor can have access to every hospital. This has  
11 produced, in our opinion, an opportunity for better  
12 care of patients and it produces a continuing post-  
13 graduate course, if you will, for all doctors because  
14 they are working together. The one exception that is  
15 made to this in this brief is if a teaching hospital is  
16 developed it does interfere with the teaching under-  
17 graduate student and we feel the open hospital system  
18 provides better care for the patients and it does make  
19 the small hospitals specifically for teaching a necessary  
20 development.

21 COMMISSIONER VAN WART: You have no  
22 such hospital in British Columbia at the present time?

23 DR. MCCREARY: No, we do not.

24 THE CHAIRMAN: What is the situation  
25 in D.V.A. and the other hospital that you mention?

26 DR. WATSON: In D.V.A. there is a  
27 measure of full-time physicians but the greater majority  
28 are practising physicians in the community who spend  
29 time there on a part-time basis or have duties given to  
30 them in the ward on a part-time basis.

In the Indian hospitals they are full-  
time salaried physicians in most cases.

change. The only hospitals in British Columbia that are closed hospitals, as you call them, would be ones under the jurisdiction of the Federal Government such as D.V.A. or the Indian hospitals. Dr. McCreary may expand on this.

DR. MCCREARY: Mr. Chairman, we in British Columbia are favoured in this regard that every doctor can have access to every hospital. This has proved, in our opinion, an opportunity for better care of patients and it produces a continuing postgraduate course, if you will, for all doctors because they are working together. The one exception that is made to this in this field is if a teaching hospital is developed it does interfere with the teaching undergraduate student and we feel the open hospital system provides better care for the patients and it does make the small hospitals specifically for teaching a necessary development.

COMMISSIONER VAL WART: You have no such hospital in British Columbia at the present time?

DR. MCCREARY: No, we do not.

MR. CHAIRMAN: What is the situation

in D.V.A. and the other hospital that you mentioned?

DR. WATSON: In D.V.A. there is a

measure of full-time physicians but the greater majority are practicing physicians in the community who spend time there on a part-time basis or have duties given to them on the ward on a part-time basis.

In the Indian hospitals they are full-

time staffed physicians in most cases.





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3 THE CHAIRMAN: On the second page of  
4 your summary, paragraph 6, para-phrasing that, are you  
5 there recommending that the Federal Government get out  
6 of the field insofar as D.V.A. and Indian hospitals are  
7 concerned when you say:

8 "...the expensive hospital facilities  
9 of the Department of Veterans' Affairs  
10 should be integrated with community  
11 hospitals..."

12 Is that what you have in mind?

13 DR. WATSON: Yes, we feel these facili-  
14 ties are excellent and could be put to much better use  
15 on a community level and are not necessarily needed in  
16 the way of veterans' services and Indian services now  
17 as much as they were when they were set up. Dr. McCreary  
18 has some comments on this that I think would be helpful  
19 to you.

20 THE CHAIRMAN: I will be glad to have  
21 them because this is, shall we say, a new idea. If you  
22 will expand it, Dr. McCreary?

23 DR. MCCREARY: Mr. Chairman, I think  
24 that the circumstances under which these hospitals were  
25 set up have modified very markedly over the years. In  
26 the case of D.V.A. hospitals, they were set up during  
27 the years in which there was no prepaid hospital system  
28 and this excellent coverage was provided for veterans.

29 In the case of the Indians, the separate  
30 Indian hospitals were set up when the rest of Canadians  
did not have access to prepaid hospitalization. We feel  
that this has been modified and changed and the same need

The CHAIRMAN: On the second page of your summary, paragraph 6, para-paragraph 6, and you there recommending that the Federal Government get out of the field hospital as D.V.A. and Indian hospitals are concerned when you say:

"...the expensive hospital facilities of the Department of Veterans Affairs should be integrated with community

is that what you have in mind?  
Dr. McCREARY: Yes, we feel these facilities are excellent and could be put to much better use on a community level and we not necessarily needed in the way of Veterans' activities and their activities as much as they were when they were set up. D.V.A. has some comments on this that I think would be helpful to you.

The CHAIRMAN: I will be glad to have them because this is what we are looking for. If you will expand it, Dr. McCREARY?

Dr. McCREARY: Mr. Chairman, I think that the circumstances under which these hospitals were set up have modified very markedly over the years. In the case of D.V.A. hospitals, they were set up during the years in which there was no prepaid hospital system and this excellent coverage was provided for veterans. In the case of the Indians, the Indian hospitals were set up when the rest of the country



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3 is not present as it then was.

4 COMMISSIONER BALTZAN: What of the  
5 occupancy of these hospitals?

6 DR. McCREARY: This varies greatly.  
7 In the case of D.V.A. hospitals the rate is in the  
8 neighbourhood of 70% but the types of patients being  
9 looked after would, in many cases, be better looked  
10 after in old people's homes. There is a gradually  
11 increasing age.

12 In the Indian hospitals the rate of  
13 occupancy tends to be low and is falling rapidly as  
14 tuberculosis among Indians becomes a diminishing thing.

15 THE CHAIRMAN: Regardless of occupancy  
16 what you are concerned with is the principle of integra-  
17 tion?

18 DR. McCREARY: That is right.

19 THE CHAIRMAN: And if your recommenda-  
20 tions should be accepted who would operate these hospitals?

21 DR. WATSON: We would feel they should  
22 be put on the same basis as the community hospitals.

23 THE CHAIRMAN: Well, on the same basis,  
24 municipal, voluntary, provincial government; what?

25 DR. WATSON: Provincial Government,  
26 B.C.H.I.S.

27 THE CHAIRMAN: Have you any hospitals  
28 operated by the Government of British Columbia now?

29 DR. WATSON: This is a method of finan-  
30 cing the operative costs.

THE CHAIRMAN: My question is, have  
you any hospitals that are operated by the Provincial





is not present as it then was.

occupancy of these hospitals?

DR. McCREARY: This varies greatly.

In the case of D.V.A. hospitals the rate is in the neighbourhood of 75% but the type of patients being looked after would, in many cases, be better looked after in old people's homes. There is a tendency

in the Indian hospitals the rate of

occupancy tends to be low and is falling rapidly as

tuberculosis among Indians becomes a diminishing thing.

THE CHAIRMAN: Regarding occupancy

what you are concerned with is the principle of integra-

tion?

THE CHAIRMAN: And if your recommenda-

tion should be accepted who would operate these hospitals?

DR. WATSON: We would feel they should

be put on the same basis as the community hospitals.

THE CHAIRMAN: Well, on the same basis,

municipal, voluntary, provincial government, what?

DR. WATSON: Provincial Government.

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THE CHAIRMAN: My question is, have

you any hospitals that are operated by the Provincial



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3 Government?

4 DR. WATSON: Not entirely, no. The  
5 Hospital Board operates each individual hospital.

6 THE CHAIRMAN: Well, I do not know if  
7 I am not making myself plain but I do not appear to be  
8 getting through to you. Hospitals operated by Boards,  
9 they would be municipal hospitals; the University Hospi-  
10 tal, if there is going to be one. Vancouver General,  
11 who operates it, for instance?

12 DR. WATSON: You mean pays for the  
13 operating expenses?

14 THE CHAIRMAN: Who operates it?

15 DR. WATSON: The Board of the hospital.

16 THE CHAIRMAN: Who appoints the Board?

17 DR. WATSON: Depending on the charter  
18 of the hospital it would be appointed by some part of the  
19 city, some part of other organizations.

20 THE CHAIRMAN: You see, what your  
21 recommendation involves is the Dominion Government aban-  
22 doning the hospital field, is that what you mean?

23 DR. McCREARY: Yes, I think so.

24 THE CHAIRMAN: All right, if they are  
25 going to abandon who is going to take their place?

26 DR. McCREARY: I think this must vary  
27 with each hospital.

28 THE CHAIRMAN: All right, with the  
29 D.V.A.?

30 DR. McCREARY: I think it will vary  
with different D.V.A. hospitals. I do not think this  
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3 and as the need for beds in the community it may mean  
4 need of another hospital and formation of a similar  
5 Board to that of the Vancouver Hospital Board to take  
6 over that one D.V.A. hospital. It may be that the need  
7 is for a teaching school in which case the University  
8 can take over but it seems to me this can only be settled  
9 on the basis of each individual city in each individual  
10 hospital if the needs arise.

11 THE CHAIRMAN: Who is going to determine  
12 those needs? How is any Board going to come into being?  
13 Who is going to foster this idea?

14 DR. WATSON: I would feel, myself,  
15 that since the D.V.A. run such a hospital now that it  
16 would be with their permission that this be done in the  
17 way of another Board taking over on a community level,  
18 whether municipal or University.

19 As Dr. McCreary mentioned, we think  
20 the Federal Government would have to be the party to  
21 agree to this and set up the transfer.

22 THE CHAIRMAN: There is no doubt they  
23 would have to agree to get out of the field but with  
24 whom would they agree, some nebulous thing or something  
25 in being?

26 DR. McCOY: What you are trying to get  
27 at is, are our hospitals at the present time, are they  
28 voluntary hospitals on the municipal level? Our Govern-  
29 ment does not run any of the large hospitals. B.C.H.I.S.  
30 merely finances them and I think they would guide our  
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4 Now, you asked a question at the start  
5 that nobody has answered and this was whether the  
6 Federal Government would get out of this field?

7 THE CHAIRMAN: If you wanted it to get  
8 out.

9 DR. MCCOY: Yes, I do not think our  
10 thinking behind this is the Federal Government would  
11 get out of this, they would be still be interested in  
12 the distribution side of this and they would still be  
13 paying for the same people they are paying for now,  
14 hospitalization for veterans and so on. The hospitals  
15 would not be run by the Federal Government, they would  
16 not be providing the care and distribution they are  
17 doing at the present time.

18 Then, conceivably, in answer to your  
19 last question, with a voluntary Board of Trustees from  
20 the community you might well take over operation of the  
21 D.V.A. hospital but the ---

22 THE CHAIRMAN: Then it would become  
23 another acute general hospital?

24 DR. MCCOY: That is right, in keeping  
25 with the rest of the hospitals in our province, that  
26 is what we visualize.

27 THE CHAIRMAN: And the same with your  
28 Indian hospitals, they become community hospitals in  
29 areas where they are not now located.

30 DR. MCCOY: That is right.

THE CHAIRMAN: Now, at several places  
in your summary and in your recommendations you deal  
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3 to pay and recommending that those who are able to pay  
4 should look after themselves - you have two classes,  
5 two divisions in the population. Does your Association  
6 see only two classes, two divisions, or is there a  
7 third class - a shaded area from those who are completely  
8 unable to pay to those who are completely able to pay?

9 DR. WATSON: Yes, we do, we see the  
10 area of the person who is perfectly able to take care  
11 of himself and between those people and the people who  
12 are indigent, we see the person who is partially medically  
13 indigent because of his conditions of health.

14 THE CHAIRMAN: Medically uninsurable?

15 DR. WATSON: Yes, so he is on a level  
16 which would be difficult for him to pay.

17 THE CHAIRMAN: That is an economic  
18 level?

19 DR. WATSON: Yes, what might be called  
20 financially indigent.

21 THE CHAIRMAN: All right. Now, what  
22 provision does your Association suggest for that group,  
23 that in-between group?

24 DR. WATSON: Well, we are recommending,  
25 we feel that we have found out a certain amount about  
26 these people and that they should be given assistance in  
27 paying their premiums on a sliding scale or partial  
28 subsidy through a government source to assist them to  
29 pay the premium. We feel there should be some way of  
30 giving them the help that they may need if this can be  
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THE CHAIRMAN: And what mechanism do



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THE CHAIRMAN: And what mechanism of





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4 you recommend to determine who should fall into that  
5 category?

6 DR. WATSON: We have not really deter-  
7 mined the mechanism of it. We feel this is something  
8 that has to be worked out at the time the scheme is  
9 designed but we have chosen two groups that we think  
10 are in need, a person who has \$2,000 or less and the  
11 household of five or more people of \$3,000 or less.  
I would like Dr. Banks to enlarge on that.

12 DR. BANKS: This problem of whether  
13 help is needed brings up the whole question of philosophy;  
14 you either have to help everybody or you have to distin-  
15 guish between those who need help and those who do not  
16 need help. No matter how you disguise your semantics if  
17 you have some way of distinguishing these people, it is  
going to be, if you like, a necessity or means test.

18 Now, recognizing this right flat on  
19 we conducted a survey amongst our population as to what  
20 the population in general thought of means tests because  
21 we have been given to understand by other people  
22 interested in this field that a means test is anathema.

23 I can report to you now that 80% or  
24 more of the population of British Columbia agree with  
25 the necessity of a means test to see whether or not  
26 government money should be spent where it is needed or  
whether it should be spread over the population in general.

27 THE CHAIRMAN: And that is the report  
28 of the survey that is contained in your main submission?

29 DR. BANKS: Yes, sir.

30 THE CHAIRMAN: In your summary on page

Watson



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THE CHAIRMAN: In your summary on page



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4, paragraph 16, you are practically on the whole of  
4 that page dealing with the various things in the province  
5 and then you go on to say:

6 "We feel that tax money should be  
7 directed to these uses as it becomes  
8 available".

9 Has your Association any order of  
10 priority to suggest as to any expansion of the use of  
11 tax money in health services in British Columbia?

12 DR. WATSON: Well, when we started  
13 writing this brief, Mr. Chairman, we thought priorities  
14 were a difficult thing to establish, but as we have  
15 gone along and discussed this more and also listened to  
16 other organizations and their opinions we certainly feel  
17 that the aspect of medical education and the lay health  
18 workers to assist in the health service is becoming a  
19 very important priority.

20 We also feel that bringing it to a  
21 local area, that the program of mental health care is  
22 a very important gap, shall we say, in our program here  
23 and we have become very concerned about the effects that  
24 medical research, or lack of medical research, has both  
25 on the quality of medical care in Canada as well as on  
26 medical education, which, of course, is an important  
27 priority that we have mentioned.

28 THE CHAIRMAN: Does your Association  
29 accept what has been suggested at other times in the way  
30 of priority of medical education, because you must have  
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4 foundation program, we then - assuming that you have a  
5 reasonable staff of personnel in British Columbia, and  
6 you indicate in your brief, apart from metropolitan  
7 areas, there appears to be sufficient hospital accommo-  
8 dation, I will put it this way, is there a real unmet  
9 need or unfulfilled need in British Columbia today?

10 DR. WATSON: Yes, the rehabilitation  
11 and chronic care person, a person needing this type of  
12 health service, is a really unmet need. We can't divorce  
13 the mental health from this aspect too, because many of  
14 the mental health centres depend on rehabilitation of  
15 the patient, and also because many of them are at the  
16 present time medically unable to be helped and there is  
a chronic care problem here.

17 I think we would agree that the need  
18 for rehabilitation and chronic care is certainly an unmet  
19 need here in British Columbia, and one that is important.

20 THE CHAIRMAN: What is the view of the  
21 British Columbia Medical Association, the British Columbia  
22 Branch of the Canadian Medical Association in regard to  
the treatment of mental health?

23 DR. WATSON: Basically we feel that it  
24 should be integrated into the community health situation.  
25 The acute cases should be treated in the acute general  
26 hospital under the care of their own physician and with  
27 appropriate help and in the community or local area that  
28 they are acquainted with and with their relatives close  
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3 or institutional type of mental illnesses should have  
4 facilities a little more distributed throughout the  
5 province than just centralized.

6 THE CHAIRMAN: What is your present  
7 situation regarding mental illness institutions?

8 DR. WATSON: We have a very large  
9 institution in one area in the Lower Fraser Valley at  
10 Essendale, a provincial mental hospital.

11 THE CHAIRMAN: With about how many  
12 patients?

13 DR. WATSON: I would say approximately  
14 6,000, six or seven thousand. It is a very large insti-  
15 tution. We have a similar institution, but of much  
16 smaller size, in Victoria and near Essendale and New  
17 Westminster there is a school, really a hospital, an  
18 institution for the mentally retarded and mentally abnor-  
19 mal child.

20 I might ask Dr. Lehman or Dr. McClure  
21 if they have anything to expand on that, if I have for-  
22 gotten anything. There are 6,198 mental hospital beds  
23 in B.C., mental care beds.

24 THE CHAIRMAN: Most of them are Essen-  
25 dale?

26 DR. WATSON: By far the great majority.

27 THE CHAIRMAN: What does your Associa-  
28 tion recommend for the future, continuation of the idea  
29 of the institution at Essendale or what?

30 DR. WATSON: No, we recommend that the  
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4 or a chronic care program along with the other persons  
5 who are ill in the same category, or same type of care  
6 needed.

7 This we feel is better psychiatric  
8 care, and we feel that it will also dispel some of the  
9 stigmas that have been attached to mental illness in the  
10 past, and really by sub-dividing these people off into  
11 areas this has been increased.

12 THE CHAIRMAN: Do you say a mental  
13 patient can be integrated into the community hospital  
14 or a wing or ward of the hospital be set aside for the  
15 mentally ill?

16 DR. WATSON: Certainly a wing or ward  
17 of the acute general hospital for the acute mental  
18 illness. With your permission I might ask a representa-  
19 tive of the Section of Psychiatry to say a few words.  
20 Dr. Halliday, who is in the audience.

21 DR. W.H. HALLIDAY: Mr. Chairman, the  
22 Section of Psychiatric Neurology feels, as Dr. Watson  
23 and the others have suggested, that the acutely disturbed  
24 mentally ill, by that we mean a wide variety of mental  
25 disorders, as this has been shown in the last 20 or 30  
26 years, could be very effectively treated in units of  
27 general hospitals, wards or separate units. With regard  
28 to the long-term or chronic case, and I don't think  
29 chronic is a very good word, I think that the establish-  
30 ment of units for chronic care for the general medical  
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16 illness. With your permission I might ask a representative  
17 of the Section of Psychiatry to say a few words.  
18 Dr. Hildrey, who is in the audience.

19 Section of Psychiatric Hildrey feels, as Dr. Watson  
20 had the others have suggested, that the severely disturbed  
21 mentally ill, by that we mean a wide variety of mental  
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23 years, could be very effectively treated in units of  
24 general hospitals, which are separate units. With regard  
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4 I think it would be the same diversifi-  
5 cation of services that would be available in the acute  
6 general hospitals. I think that the principle should be  
7 that the ill person should be treated as near to his  
8 community whether he is acutely ill or whether he is  
9 ill from long-term illness.

10 THE CHAIRMAN: Thank you very much.

11 Is the British Columbia Branch of the  
12 Canadian Medical Association satisfied with the coverage  
13 now being provided by the two main non-profit organiza-  
14 tions, two main non-profit doctor-sponsored organizations  
in British Columbia?

15 DR. WATSON: As we have progressed  
16 we feel we have increased this coverage, but certainly  
17 we feel that there are certain aspects that should be  
18 included and we realize there are reasons for this and  
19 in many cases we feel it would be advisable for them to  
20 expand to some extent, although we are very satisfied  
21 that good essential medical care is available to people  
under this group.

22 There are some aspects that may be  
23 necessary in the future to expand.

24 THE CHAIRMAN: Would you accept this  
25 as valid or not, that generally speaking those wholly  
26 excluded from coverage need it the most?

27 DR. WATSON: Not entirely; the group,  
28 when it is taken into account that 75% of the group will  
29 be brought into a scheme of this nature if they wish to,  
30 at least, it is required before they come into a group these

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category of services that would be available in the acute general hospitals. I think that the principle should be that the ill person should be treated as near to his community wherever he is actually ill or whether he is ill from long-term illness.

THE CHAIRMAN: Thank you very much.

Is the British Medical Association in favour of the Canadian Medical Association satisfied with the coverage now being provided by the two main non-profit organizations, two main non-profit doctor-sponsored organizations in British Columbia?

DR. WATSON: As we have progressed

we feel we have increased this coverage, but certainly we feel that there are certain aspects that would be included and we realize that we have a long way to go in many cases we feel it would be desirable for them to expand to some extent, although we are very satisfied that good essential medical care is available to people under this system.

There are some aspects that may be

necessary to expand to some extent.

as well as for, but generally speaking, those who are excluded from coverage are the most

to be in a state of ill health in any way, and it is not until they are in a state of ill health that they are excluded from coverage.





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3 plans, you are getting many of the people in that large  
4 number who are needful of this care on a medical unin-  
5 surable point of view or low income point of view.

6 THE CHAIRMAN: That covers those who  
7 are insurable as part of a group?

8 DR. WATSON: That is right.

9 THE CHAIRMAN: Those who are not  
10 insurable as part of a group, the individual that is  
11 self-employed and so forth, etc.?

12 DR. WATSON: You mean the part that  
13 has been left out by these. We are certainly quite satis-  
14 fied that there are many people who have been left out be-  
15 cause of the particulars of underwriting for these schemes.

16 This is our whole point. We want to  
17 expand this to meet it. In M.S.I., however, we have  
18 been attempting to cover people in this category that  
19 are not insurable as groups. We have brought it down  
20 to any self-employed person in British Columbia is able  
21 to buy comprehensive coverage from M.S.I. at a reasonable  
22 premium.

23 THE CHAIRMAN: Comprehensive in terms  
24 of your own definition?

25 DR. WATSON: Yes.

26 THE CHAIRMAN: That recognizes exclu-  
27 sions, recognizes waiting periods?

28 DR. WATSON: It recognizes the exclusion  
29 of refractions and routine physical check-ups, well  
30 check-ups; a person in good health who wants a check-up.

There are very few waiting periods,  
if any, other than maternity or conditions that are



plans, you are getting many of the people in that large number who are needed of this care on a medical unit-  
 sample point of view or low income point of view.

THE CHAIRMAN: That covers those who

and insurance is part of a group?

DR. WATSON: That is right.

THE CHAIRMAN: Those who are not

responsible as part of a group, the individual that is

self-employed and so forth, etc.?

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to say as self-employed person in British Columbia is able

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DR. WATSON: Yes.

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sions, recognizes waiting periods.

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of pre-existing conditions and routine physical check-ups, well

check-ups; a person in good health who wants a check-up.

There are very few waiting periods.

It is a matter of a relatively few conditions that are



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3 already under care when the patient joins the group.

4 THE CHAIRMAN: What about age limita-  
5 tion, if any?

6 DR. WATSON: There are no age limita-  
7 tions on the self-employed person. I believe that is  
8 correct.

9 THE CHAIRMAN: Is there an age limita-  
10 tion at all?

11 DR. WATSON: Dr. Boyd?

12 DR. BOYD: M.S.I. has a partial limited  
13 coverage plan which is available to certain individuals  
14 and a comprehensive plan which is available to groups.  
15 These groups have been reduced to groups of one which  
16 means a self-employed person can buy a comprehensive  
17 coverage as long as he is self-employed. I don't think  
18 there is any age limit.

19 If he is an individual joining the  
20 partial plan there is an age limit of 65. The Executive  
21 Director is in the room if you want to call on him.

22 THE CHAIRMAN: We will be hearing from  
23 the plan Thursday morning, I think. Thank you very much  
24 gentlemen. Dr. Baltzan?

25 COMMISSIONER BALTZAN: Dr. Watson, I  
26 will pass over your coloured pages. I have no questions  
27 arising out of them. On the white pages I would like to  
28 turn to No. 32.

29 DR. WATSON: Page 32?

30 COMMISSIONER BALTZAN: Page 32, 108,  
you mention a very intriguing thing about an independent  
board of administration, administrative board, staffed



under come when the patient comes to the

tion, if any?

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tions on the self-employed person. I believe that is

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coverage is in the plan if you want to call on him.

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the plan should be considered? I don't know if you

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3 by University, professional and government members. Are  
4 you suggesting this on a provincial basis or federal  
5 basis?

6 DR. WATSON: Well, we have discussed  
7 this and feel this is a very worthwhile organization,  
8 and it would appear that it would be needed on both  
9 levels, one on a federal basis and one local, on items  
10 that enter the jurisdiction of the province, also on a  
11 provincial basis.

12 This is a new idea and like all new  
13 ideas there are many things to work out about it and  
14 think about. We have done a good deal of thinking  
15 about this. We feel it is a worthwhile recommendation.

16 COMMISSIONER BALTZAN: I don't deny  
17 that. It is something in the nature of a planning committee  
18 as well as investigating the need for an organization.  
19 Is that what you mean by research?

20 DR. WATSON: We thought of it as an  
21 advisory board where some organization may, if they have  
22 an idea for improving or research in health services,  
23 they may go to this board to ask their assistance to  
24 look into this matter or to assist them in performing  
25 experiments in the field of research, advisory type of  
26 set-up.

27 COMMISSIONER BALTZAN: Is it too prema-  
28 ture at the moment to inquire who is going to finance it,  
29 University, government or the profession or all of them?

30 DR. WATSON: We recommend in the brief  
we feel the financing should be a shared thing between  
the Provincial Government and Federal Government.

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4 Certainly we feel ~~our~~ thinking wouldn't be against the  
5 medical profession entering into a share of these costs.

6 COMMISSIONER BALTZAN: Thank you very  
7 much. Would you turn to page 51, sir, and your asso-  
8 ciates, 174, where you point out that your approved  
9 service plans cover general practitioner service and  
10 specialist service on a referral basis.

11 Now, the extra billing from a doctor,  
12 for a specialist for extra services that a specialist  
13 renders, I put it to you this way: before you answer,  
14 it has been called, among other things, a luxury service;  
15 that is why I want your definition.

16 DR. WATSON: In this paragraph, we  
17 are dealing and attempting to define that the service  
18 plan, as we see it, should be set up for rendering  
19 services of general practitioners and those services of  
20 any consultant if referred to them by the general practi-  
21 tioner.

22 However, we have also recognized the  
23 fact that many persons in obtaining their medical care  
24 wish to go directly to a specialist; and if so, the  
25 service plans will be the specialist up to the amount  
26 that they would pay a general practitioner for rendering  
27 the service.

28 We feel, then, that the specialist  
29 has every privilege to extra-bill the patient or charge  
30 them the difference between the general practice rate  
and the specialist rate according to the fee schedule,  
and that this is for payment for something that the  
patient has not contracted for in their service plan.

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4 It is something above the service that  
5 they have paid for and you might call it a luxury  
6 service. You might call it a difference between them  
7 obtaining something under their insurance that they have  
8 not paid for in the original premium.

9 COMMISSIONER BALTZAN: Do you find it  
10 easier in any sort of prepaid plan to have your base  
11 line that which covers the majority of people rendering  
12 the service like the general practitioner?

13 THE CHAIRMAN: Dr. Watson, before you  
14 leave that, I have occasion to go to an eye specialist  
15 from time to time. In British Columbia, would I go to  
16 my family physician and be directed by him to the eye  
17 specialist?

18 DR. WATSON: If you wish to, sir.  
19 Yes, very definitely.

20 THE CHAIRMAN: Not if I wish to; I  
21 mean to say, would I, in any common sense, do it?

22 DR. WATSON: It depends on the condition.  
23 I think it would be a very sensible thing to do if you  
24 were not sure of the diagnosis.

25 THE CHAIRMAN: Let us say that at my  
26 age I have had a little information on that point now,  
27 and I just think I am not seeing well enough and maybe  
28 I should have another examination. So, am I expected  
29 to go to my family physician in British Columbia and be  
30 directed by him to the eye specialist in order that my  
contract may pay the specialist's fee?

DR. WATSON: Yes, if you ---

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DR. WATSON: Yes, if you ---

THE CHAIRMAN: I go direct to him; he



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3 gets the general practitioner's fee, and I get a bill  
4 for the excess?

5 DR. WATSON: That is right. If you  
6 went directly to your general practitioner, and he felt  
7 that your condition needed the services of an ophthalmo-  
8 logist, he would bill you and then the plan would pay.

9 THE CHAIRMAN: Surely to heaven, in  
10 the matter of a general practitioner, he doesn't do eye  
11 refractions?

12 DR. WATSON: If you were sure you  
13 wanted a refraction. My point was if you were not sure  
14 of your diagnosis, it would be very advisable to have a  
15 complete check-up before you went on to specialist  
16 services.

17 THE CHAIRMAN: The man convinced  
18 against his will remains unconvinced still, Doctor.

19 COMMISSIONER FIRESTONE: Of course,  
20 sir, you realize that this whole examination by the  
21 medical practitioner would not be covered?

22 DR. WATSON: Would not be covered?

23 COMMISSIONER FIRESTONE: No. If it  
24 were just general check-up, as you have recommended?

25 DR. WATSON: No, this would not be so.  
26 If a person came complaining of visual defects, this  
27 check-up would be covered. Perhaps Dr. Banks may have  
28 a point on that.

29 DR. BANKS: I think that you perhaps  
30 have over-simplified it.

THE CHAIRMAN: Simplification is  
really not too difficult a thing.

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4 DR. BANKS: This is specific. If you  
5 are not seeing right, you might have diabetes, which  
6 would affect your vision. Or, it might be anaemia, or  
7 a heart condition.

8 THE CHAIRMAN: Someone might have  
9 socked me with a stone. I am talking about the average  
10 person wearing glasses -- and there are thousands and  
11 thousands of us. Now, every time we figure we ought to  
12 get a new pair of glasses, or we break our glasses, we  
13 ought to go to a general practitioner and be directed  
14 by him to the eye specialist?

15 DR. WATSON: Not at all, sir. In these  
16 circumstances, even the specialist's fee would not be  
17 covered in our plan, because refractions are not  
18 covered.

19 THE CHAIRMAN: If you had said that  
20 in the first place!

21 DR. WATSON: I did not wish to mis-  
22 direct you, sir.

23 THE CHAIRMAN: It is part of my life  
24 to listen to much misdirection.

25 COMMISSIONER BALTZAN: Just to pursue  
26 that, not in an embarrassing way, but I am trying to,  
27 and I have asked other places and you have already  
28 answered this thing is a base line, but supposing you  
29 could get a base line to cover these things the Chairman  
30 has asked about, such as gastroenterology, and neuro-  
physiology, do you think you could make one plan that  
would cover all these things, or would you still have to  
have two plans?

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answered this thing as a bare line, but supposing you

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has asked about, such as gastroenterology, and neuro-

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4 DR. BANKS: I am not sure I understand  
5 what you mean. You mean a base line of specialist care,  
6 and base line of general practitioner care?

7 COMMISSIONER BALTZAN: Yes.

8 DR. BANKS: I do not think we could  
9 give you a great deal of experience on this. We have  
10 not gone into it at all. We have not actually considered  
11 that this was a necessary type of care. If there is  
12 anyone here that could expand on this. Perhaps Dr.  
13 Lehman.

14 DR. LEHMAN: I believe, sir, that we  
15 have what you are referring to. We have a plan covering  
16 specialist care when needed right now.

17 COMMISSIONER BALTZAN: Unreferrable?

18 DR. LEHMAN: Unreferrable, yes, and  
19 our plan is -- the economy of it is to cover both  
20 specialist and general practitioner care. What it is  
21 not planned to cover is what you would call unnecessary,  
22 frivolous care in the hands of a specialist.

23 COMMISSIONER FIRESTONE: Such as?

24 DR. LEHMAN: A person who feels he has  
25 anaemia and wants to go to an internist to have his  
26 anaemia checked. He is making his own diagnosis. This  
27 produces a very costly service.

28 DR. BLAIR: There is also some difference  
29 of opinion amongst the medical profession as to  
30 whether or not this is a luxury service. As you can  
see from my remark, I am a specialist, and I do not  
think it is a luxury service. The general practitioner  
probably thinks it is. I hear the remark of luxury



DR. BARKER: I am not sure I understand what you mean. You mean a base line of specialist care, and base line of general practitioner care?

DR. BARKER: I do not think we could give you a great deal of experience on this. We have not gone into it at all. We have not actually considered that this was a necessary type of care. If there is anyone here that could expand on this, perhaps Dr.

DR. LEHMAN: I believe, sir, that we have what you are referring to. We have a plan covering specialist care when needed right now.

DR. LEHMAN: Understandable, yes, and our plan is -- the economy of it is to cover both specialist and general practitioner care. What it is not planned to cover is what you would call unnecessary, trivial care in the hands of a specialist.

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4 service coming up. I do not think this is. As you  
5 probably surmise, there is a considerable difference of  
6 opinion as regards whether or not this is.

7 COMMISSIONER BALTZAN: Which leads  
8 me in this direction, that this question of extra-billing  
9 is a confounded nuisance so far as the subscribers are  
10 concerned, and most doctors will agree it is an embarrass-  
11 sing thing for them.

12 If we could hear from you at some time  
13 or other how you can make a joint proposition to eliminate  
14 these referrals to seeing specialists, it would be very  
15 helpful, and that is the reason I raised this question  
16 and some time perhaps you could give this some thought.

17 DR. WATSON: We will try, Dr. Baltzan.  
18 We have thought a great deal about it. It is a difficult  
19 problem.

20 COMMISSIONER BALTZAN: I notice on  
21 page 78, Dr. Watson, paragraph 254:

22 "Many of the so-called drugs appearing  
23 almost daily on the market are in fact  
24 simply re-issues of well-established  
25 preparations..." etc.

26 My question to you is this: is all  
27 this which amounts to, as per your last line on the same  
28 page 78, is all this amounting to 29.2% helpful to the  
29 doctors in meeting the up-to-date treatment of their  
30 patients? Can we do with less of this promotional  
stuff and still -- I should put it this way: can you do  
with less of this promotional stuff and still do up-to-  
date prices?



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DR. WATSON: We will try, Dr. Baxter.

We have thought a great deal about it. It is a difficult

problem.

COMMISSIONER BAXTER: I notice on

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"Many of the so-called group appearing

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this which amounts to, as per your last line on the same

page 78, is all this amounting to 50.25 being left to the

doctors in relation to the up-to-date treatment of their

patients? Can we do with less of this promotional

stuff and still -- I should put it this way: can you do

with less of this promotional stuff and still be up-to-





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3 DR. WATSON: I do not think there is  
4 any doubt about the fact that we can.

5 COMMISSIONER BALTZAN: Thank you. I  
6 have not too much more.

7 At page 72 on the white paper, para-  
8 graph 235:

9 "The plan administrators themselves  
10 can abuse the principle of prepaid  
11 insurance by virtue of the authority  
12 they possess. As the paying agencies,  
13 they could make inadequate payment for  
14 certain medical services when these do  
15 not completely coincide with the  
16 description of any service in the  
17 agreed Fee Schedule. To control any  
18 such tendency, a committee of doctors  
19 appointed by the C.M.A. - B.C. Division  
20 and known as the Reference Committee,  
21 acts as a Court of Appeal to which any  
22 doctor may bring any particular instance  
23 of alleged underpayment".

24 My only question is this: is there a  
25 parallel Reference Committee for adjustments from any  
26 subscriber's complaints or claims?

27 DR. WATSON: Yes. Now, when you use  
28 the word "subscriber" ---

29 COMMISSIONER BALTZAN: Well, receiver.  
30 I do not know which word you use.

1 28 DR. WATSON: Well, a member of one of  
29 the approved prepaid plans -- their agent for talking  
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3 about this is on their approved prepaid plan, and these  
4 plans have access to this Reference Committee. The  
5 medical directors of these plans can also send parti-  
6 culars to the Reference Committee.

7 COMMISSIONER BALTZAN: To the same  
8 Committee?

9 DR. WATSON: To the same Committee.  
10 If this person is not under one of the approved prepaid  
11 plans, and they are a member of the general public,  
12 possibly independent in their accounts, if they wish to  
13 question a fee or understand it, then we have another  
14 Committee which we call the Mediation Committee, to  
15 meet with them to discuss their problem with respect to  
16 this aspect.

16 COMMISSIONER BALTZAN: It is not  
17 mentioned here, or have I been skipping pages?

18 DR. WATSON: It is mentioned here,  
19 although it is not gone into in great detail.

20 COMMISSIONER BALTZAN: You call it  
21 the Mediation Committee?

22 DR. WATSON: The Mediation Committee,  
23 yes.

24 COMMISSIONER BALTZAN: On page 71,  
25 paragraph 232, you have started campaign protection  
26 against possible abuse by the patient and you claim  
27 certain accomplishments.

28 Was this campaign started in order to  
29 help reduce the costs of rendering these services? I  
30 presume that is it? Is that what you say?

DR. WATSON: Paragraph 232?





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presume that is it? Is that what you say?



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4 COMMISSIONER BALTZAN: I think it is  
5 232, yes.

6 DR. WATSON: Yes. This, of course, is  
7 a procedure undertaken by the prepaid plan, M.S.A., not  
8 by us necessarily. It was certainly designed to bring  
9 home to the subscriber of their plan the fact that  
10 utilization is a very costly business and that they  
11 should see their doctor when necessary, but to make  
12 sure it is necessary. I am quite sure it is designed  
13 to reduce costs, yes.

14 COMMISSIONER BALTZAN: I bring this up  
15 because it might be considered something in the form of  
16 a deterrent or inhibition and some people rather object  
17 to that.

18 I see that you have reduced in 1961  
19 these -- what some people would call -- frivolous calls.  
20 Has this been, in your estimation, a deterrent? Has it  
21 been harmful? Has it prevented people from coming at  
22 the first indication?

23 DR. WATSON: I do not believe so at  
24 all, Dr. Baltzan. I would not consider it has been any  
25 deterrent.

26 COMMISSIONER BALTZAN: It is from that  
27 point of view that I ask this question.

28 I think I will have just one word only,  
29 and I will go to the pink pages. No. 2 -- page 2, which  
30 is really the final of the paragraph commencing, the  
second paragraph from the top.

DR. WATSON: Would you tell us what  
section?







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4 COMMISSIONER BALTZAN: The general  
5 practitioners, I think. You refer to the average  
6 general practitioner working about 62 hours, etc., etc.  
7 And then, in spite of the hours, most practitioners  
8 derive great satisfaction from their work. I heard the  
9 answer that there is no limitation or restrictions on  
10 general practitioners having availability and recourse  
11 to, I think Dr. McCreary said, all the general hospitals  
12 in British Columbia except D.V.A. member and so on?

13 DR. WATSON: That is right, sir.

14 COMMISSIONER BALTZAN: My final and  
15 last question, and I will direct it to Dr. McCreary;  
16 have you general practitioners on the Faculty of Medicine?

17 DR. MCCREARY: Yes, we have, sir. We  
18 have two teaching exercises within the Faculty of Medicine  
19 in which general practitioners are involved, and those  
20 members of the general practice group are on the Faculty  
21 of Medicine.

22 COMMISSIONER BALTZAN: Thank you. It  
23 would have helped me so much if I had had that a couple  
24 of months ago.

25 That is all, Mr. Chairman.

26 COMMISSIONER GIRARD: Mr. Chairman,  
27 I would like to direct my question to Dr. Watson.

28 On page 34, Section 114; you state here:  
29 "We are somewhat concerned with the  
30 availability of registered nurses to  
assist us in the care of our patients".  
And you say in paragraph 115 that  
several hospitals in British Columbia have had to close



DR. WILLIAM W. WATSON: The general

practitioner, I think, has a better to the average  
general practitioner working about 60 hours, etc., etc.

desire great satisfaction from their work. I heard the  
answer that there is no limitation on restrictions on  
general practitioners having availability and resources

in British Columbia, except Dr. A. Watson and Dr. B.

DR. WATSON: That is right, sir.

DR. WILLIAM W. WATSON: My friend, and

last question, and I will direct it to Mr. Watson;

have you general practitioners in the Faculty of Medicine

Dr. Watson: Yes, we have, sir. We

have two remaining, employed within the Faculty of Medicine

in which general practitioners are involved, and those

members of the general practice group are on the full list

DR. WILLIAM W. WATSON: Thank you, Dr. B.

would have helped me in that if I had had that a couple

of years ago.

That is all, Mr. Chairman.

I would like to direct my question to Dr. Watson.

On page 34, Section 114; you state here

"We are somewhat concerned with the

availability of registered nurses to

assist us in the care of our patients."

Is that any in paragraph 115 that

general hospitals in British Columbia have had to close



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4 wards temporarily.

5                   We in the east are of the opinion  
6 that all our nurses want to go to British Columbia, and  
7 I have always been under the opinion that British  
8 Columbia was the only province where there was not a  
9 shortage of nurses, so I was rather intrigued by this  
10 statement.

11                   Is there such a shortage of nurses  
12 in British Columbia, and outside of the reasons that  
13 you give on page 46, paragraph 157, do you have any  
14 other reasons?

15                   DR. WATSON: Mr. Chairman, the fact  
16 is that we are also very close to California and Hawaii,  
17 and they seem to pass through here.

18                   However, to answer your question more  
19 directly, we do have a shortage of nurses, registered  
20 nurses. This is my experience at my own hospital, that  
21 we find it very difficult to obtain replacements. We  
22 find it very difficult to obtain summertime relief, and  
23 I think this is a real problem that is not at all solved  
24 here.

25                   I have not been able to see what you  
26 want on page 46, Miss Girard.

27                   COMMISSIONER GIRARD: You give one  
28 reason on page 46, paragraph 157, and I just hesitate  
29 to mention that one. It is pay.

30                   But you do bring that reason up as one  
of the reasons, so I wonder if you care to elaborate on  
that, or whether there are any other reasons that you  
thought valuable for this shortage?







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4 DR. WATSON: One of the main problems  
5 is the difficulty of increasing salaries for nurses for  
6 the more senior and more trained and more experienced  
7 nurse because of the budget restrictions that all hospi-  
8 tals are under with British Columbia Hospital Insurance  
9 Service.

10 The budget aspect is one that is behind  
11 the so-called autonomous control of the hospital by its  
12 Hospital Board, and staff costs are by far the greatest  
13 in running the hospital. Nursing service has found it  
14 extremely difficult to get increases as well as to recog-  
15 nize superior experience by training or loyalties to the  
16 hospital.

17 I believe that salaries have a great  
18 deal to do with the loss that we have of nursing persons,  
19 registered nurses, who train here and then go to Califor-  
20 nia or the southern United States.

21 COMMISSIONER GIRARD: Then, would you  
22 agree with the fact that as recompense to a good bedside  
23 nurse we must give her promotion so that we can give her  
24 a higher salary, instead of being able to keep her at  
25 the bedside where she is doing her best work? To go  
26 along with this, this is one of the reasons that has  
27 been given.

28 DR. WATSON: My personal thinking is  
29 she should be. She should be given a much greater oppor-  
30 tunity to be at the bedside which some of our administra-  
tive workers will not allow her to be.

31 COMMISSIONER GIRARD: Dr. Watson, on  
32 page 34 ---







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4 THE CHAIRMAN: Before you leave that  
5 section, Miss Girard, has your Association any opinion  
6 to offer on whether or not the budgetary provisions  
7 permit of sufficient nurses in the hospitals at the  
8 present time in British Columbia?

9 DR. WATSON: Generally speaking, yes,  
10 we feel that the budgetary technique of government  
11 operating costs as applied to each individual hospital  
12 often controls staff and very frequently ---

13 THE CHAIRMAN: Does it give sufficient  
14 nurses for the proper operation of the hospital?

15 DR. WATSON: In many aspects where we  
16 have studied it in particular hospitals this is not the  
17 case, they do not have sufficient nursing coverage.

18 THE CHAIRMAN: But you say in para-  
19 graph 114 on page 34:

20 "We note that the British Columbia  
21 Hospital Insurance Service budgets  
22 for three hours per patient day per  
23 registered nurse for one of its new  
24 hospitals".

25 Is that figure a general one throughout  
26 the province or only in relation to this one new hospital?

27 DR. WATSON: I could not say whether  
28 it is a general figure. This is a question Dr. Bell-  
29 Irving could give you some information on.

30 DR. BELL-IRVING: If I might speak  
from a number of aspects; firstly, when our nurses are  
paid or, rather, a hospital budget is setup, you get  
so much for a nurse regardless of her experience.





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3 THE CHAIRMAN: I understand there are  
4 so many beds in the hospital and it is calculated at  
5 three hours per patient day?

6 DR. BELL-IRVING: I was coming to this.  
7 This restricts us in a number of ways; firstly, it does  
8 not recognize in any way seniority of the nurse so if,  
9 in your hospitals, you have a rather large number of  
10 senior nurses you get penalized, you cannot afford so  
11 many nurses and you have to find some way around or even,  
12 upon occasion, close the ward for a month or two to meet  
13 your budget which you do not wish to do.

14 The answer is, yes, it does restrict  
15 us.

16 Secondly, there are a number of other  
17 ways in which we could make better use of our nurses.  
18 This is one of the things we had in mind, nurses for  
19 administrative, research; if I could draw your attention  
20 to ---

21 THE CHAIRMAN: I do not want to leave  
22 this area for a moment.

23 DR. BELL-IRVING: I assure I am not  
24 leaving it.

25 THE CHAIRMAN: For my part I want to  
26 stay with it, keep closer than you intend to.

27 DR. BELL-IRVING: If I might quote;  
28 the use of nurses in one hospital was approximately  
29 12.4% of the nurse's time spent with the patient and the  
30 rest was spent doing other things than nursing services.  
We think we could do a great deal more for the nurses,  
for their morale and for ours and keep costs down; we







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4 might be able to do more with the money. At the moment  
5 the way we are doing it we are certainly restricted in  
6 the use we can put our nurses to.

7 THE CHAIRMAN: Could you answer this  
8 question, please? Is this formula of three hours per  
9 person day a reasonable formula in estimating budgets  
10 for nurses in hospitals in British Columbia?

11 DR. BELL-IRVING: Not of necessity.  
12 There is no answer. This is what we are accustomed to  
13 but we might be able to make better use than three hours.  
14 At the moment it is restricting our care so that the  
15 answer is a twofold one.

16 THE CHAIRMAN: We accept that the  
17 agreement under the Hospital and Diagnostic Services  
18 Act, that is by the Dominion Government and the Province  
19 of British Columbia, requires, or rather stipulates,  
20 that there will be division of cost for all necessary  
21 nursing services.

22 What happens in British Columbia where a  
23 physician states that a patient must have continuous  
24 nursing service?

25 DR. BELL-IRVING: We get it.

26 THE CHAIRMAN: From what source?

27 DR. BELL-IRVING: For instance, if I  
28 write orders that such-and-such a patient must have  
29 continuous care, the hospital obtains a nurse, a special,  
30 and charges B.C.H.I.S.

THE CHAIRMAN: That is the way it is  
worked?

DR. BELL-IRVING: Yes.



the way we are doing it we are certainly restricted in the way we can put our answers to.

THE CHAIRMAN: Could you answer this

question, please? Is this formula of three hours per person a reasonable formula in estimating budgets for nurses in hospitals in certain hospitals?

MR. GALLAGHER: Not at all.

There is no answer. This is what we are accustomed to but we might be able to make better use than three hours. At the moment it is restricting on costs so that the answer is a twofold one.

THE CHAIRMAN: Is it possible that the

agreement with the Hospital and Health Care Services Act, that is by the Hospital Government and the Province of Ontario, is a reasonable, or rather equitable, that there will be a situation of cost for all necessary nursing services.

MR. GALLAGHER: I am not sure of that.

Physician states that a patient may have continuous nursing services.

MR. GALLAGHER: No, not at all.

MR. GALLAGHER: For instance, if I

write orders that soon-and-such a patient must have continuous care, the hospital provides a nurse, a specialist, and charges a certain fee. That is the way it is





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4 THE CHAIRMAN: They do not charge the  
patient?

5 DR. BELL-IRVING: No.

6 THE CHAIRMAN: Thank you very much.

7 COMMISSIONER GIRARD: If I may follow  
8 on a little further; would it ever happen that the physi-  
9 cian would state the care he wants for his patient and  
10 this would go to the Director of Nursing and the Director  
11 of Nursing, if she has enough personnel, could put one  
12 of her own nurses on full-time for this patient or else  
she could hire a special nurse?

13 DR. BELL-IRVING: That is the way it  
14 is done in our hospital. Perhaps it is different in  
15 other hospitals but in ours there is a Board of three  
16 and you make an application to do this to B.C.H.I.S.

17 If the Nursing Superintendent, depen-  
18 ding on the hour, has not got the necessary nursing care,  
19 she is authorized to get it and she does. This is quite  
a recent development in the service.

20 COMMISSIONER GIRARD: Now, I would like  
21 to go back to the three hours; where does this three-hour  
22 ratio come from?

23 DR. BELL-IRVING: I honestly do not  
24 know.

25 COMMISSIONER GIRARD: Shall I tell you?  
26 This was a ratio that came from the National League of  
27 Nurses in the United States and it was worked out in  
28 1949 or 1950. For want of a better measuring tool for  
29 nurses, to get the number of nurses we need, we have  
30 been using this since then and it is outmoded and does



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patients?

DR. BELL-IRVING: No.

THE CHAIRMAN: Thank you very much.

COMMISSIONER GIBBS: If I may follow

on a little further; would it ever happen that the physician would state the case he wants for his patient and this would go to the Director of Nursing and the Director of Nursing, if she has enough personnel, would put one of her own nurses on full-time for this patient or else she could hire a special nurse.

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DR. BELL-IRVING: I honestly do not

know.

COMMISSIONER GIBBS: Shall I tell you?

This was a radio that came from the National League of Nurses in the United States and it was worked out in 1941 or 1950. For want of a better measuring tool for nurses, to get the number of nurses we need, we have been using this since then and it is somewhat and does



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3 not give us any kind of measure that we need for nursing  
4 today.

5 I was happy to hear you say you do not  
6 think this three hours was adequate.

7 DR. BELL-IRVING: We are most unhappy  
8 with it.

9 COMMISSIONER GIRARD: If you open a  
10 hospital and try to figure out the number of nurses and  
11 say that you have four hundred patients and three hours  
12 a nurse; figure that out and this is going to give you  
13 the number of nurses you need; you will find that when  
14 you open the hospital you will not have enough nurses  
because it is not adequate.

15 This may work out adequately in some  
16 services in some parts of the hospital but it will be  
17 totally inadequate in others; in neurosurgery or cardio-  
18 surgery, in pediatrics, it won't be adequate. I am glad  
19 you do agree with this.

20 On page 25, paragraph 87, you state  
21 that:

22 "Less than 200 miles as the crow flies  
23 from Vancouver, the Anahim Reserve,  
24 there is a community of 2,000 Indians  
25 who have no hospital or medical care,  
26 nor any resident doctor closer than  
27 90 miles away over a very poor road.  
28 According to two nursing sisters on  
29 the reserve, these people often have  
30 their babies at home and sometimes  
even in the fields, delivered by







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4 themselves or by their husbands, with  
5 attendant high mortality and morbidity  
6 figures".

7 This is a poor situation as you relate  
8 it.

9 In another province they have tried  
10 to counteract by training nurse midwives; how does the  
11 medical profession in this province feel about this idea  
12 of training nurse midwives?

13 DR. WATSON: We have not had an actual  
14 discussion or opinion on this. I would like to refer  
15 this, if I could, to Dr. Hobbs, who is in the audience.

16 DR. HOBBS: I do not speak with the  
17 authority of my section of the British Columbia Division  
18 on this point. I believe a nurse that is well-trained  
19 as a midwife would be far better than not having a  
20 doctor within call for a difficult maternity case.

21 This area where the Indian population  
22 is is an isolated area and I can see little hope of  
23 getting adequate medical personnel to go to that area  
24 where they could be used because there just is not  
25 enough private practice in the area to encourage a  
26 doctor to go there. As far as I am concerned I would  
27 personally be in favour if there is a small hospital  
28 there of giving the nurse a certain amount of maternity  
29 training, not necessarily setting her up as a midwife,  
30 but bringing her into the maternity hospital and perhaps  
giving her three or four months of good obstetrical  
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4 I do not think, speaking as a profes-  
5 sion, we would encourage training nurse-midwives in  
6 Canada. Does that answer your question?

7 COMMISSIONER GIRARD: Yes, it does.

8 THE CHAIRMAN: Perhaps I might direct  
9 a question to Dr. McCreary; has the Medical Association  
10 given any consideration to having the same type of  
11 course as the medical school in Alberta where there is  
12 a course on midwifery?

13 DR. MCCREARY: Not as yet.

14 THE CHAIRMAN: The doctors suggested  
15 there was no place in Canada where it was being done  
16 but we know it is being done in Alberta.

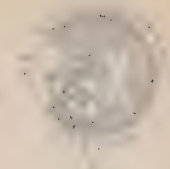
17 DR. MCCREARY: I know many of us feel  
18 this is a basic essential in Canada but I do not think  
19 it needs to be done in every school.

20 We have an area in which the population  
21 is very sparse and we are not going to get the doctors  
22 in with the usual distribution. Most of the public  
23 health nurses in this area are not Canadian girls, they  
24 have not had the training to equip them for this work.

25 We find most of these girls are English  
26 or Australian. We feel, at least in one place in Canada,  
27 there should be a spot where nurses could be trained in  
28 this way.

29 THE CHAIRMAN: That is Alberta, at the  
30 present time, and, therefore, would there be an objection  
on the part of the profession to the importation of the  
graduate from the school in Alberta?

DR. HOBBS: I would not think so, sir.



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DR. McFARLEY: I would not think so, sir.



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4 COMMISSIONER GIRARD: As you understand,  
5 this course is going to registered nurses and it is on  
6 a post-graduate level and it is recognized as the equiva-  
7 lent of part I of the midwifery course that is given in  
8 England. It seems to have given good results in that  
9 province so far and that is why I wanted the opinion of  
10 the medical profession here.

11 COMMISSIONER VAN WART: Mr. Chairman,  
12 I would like first of all to draw out the relationship  
13 of the profession to certain medical organizations and  
14 also the functions of six or seven medical organizations.

15 I think probably your Secretary, Dr.  
16 McCoy, would be a very good one to answer these questions.  
17 The College of Physicians and Surgeons of British Colum-  
18 bia is the first organization; could you tell me briefly  
19 what its function is and its relation to the profession?

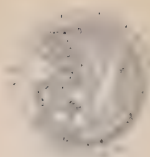
20 DR. MCCOY: They will be presenting  
21 their own brief at a later time but their relationship  
22 to the profession is that of licensing and discipline,  
23 those are the two fields that they primarily are  
24 interested in. Does that answer what you wished to know?

25 COMMISSIONER VAN WART: Yes. The  
26 Canadian Medical Association, B.C. Division?

27 DR. MCCOY: That is the organization  
28 that looks after all other affairs of doctors. They  
29 are an organization of the doctors themselves whereas  
30 the College of Physicians and Surgeons is really, in  
one respect, an arm of the law because they do their  
work on behalf of all citizens.

The British Columbia Medical Association





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McCoy, would be a very good one to answer those questions. The College of Physicians and Surgeons of British Columbia is the first organization; could you tell me briefly what its function is and its relation to the profession?

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The British Columbia Medical Association



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3 is an organization of the doctors of British Columbia  
4 which looks after economic affairs and the doctors'  
5 relations with government and relations with other  
6 organizations and so forth - education.

7 COMMISSIONER VAN WART: A voluntary  
8 organization?

9 DR. McCOY: Yes.

10 COMMISSIONER VAN WART: Not a compul-  
11 sory membership?

12 DR. McCOY: Correct.

13 COMMISSIONER VAN WART: The Vancouver  
14 Medical Society?

15 DR. McCOY: This is an organization of  
16 the doctors in Vancouver alone which approximate about  
17 half the doctors in British Columbia and this is also  
18 on a voluntary basis.

19 COMMISSIONER VAN WART: The College of  
20 General Practice in British Columbia?

21 DR. McCOY: There is no such organiza-  
22 tion. There is a College of General Practice of Canada  
23 with a British Columbia Chapter; this is the provincial  
24 Chapter of the national organization.

25 COMMISSIONER VAN WART: And they cover  
26 what groups? Is there a Chapter in all provinces and territories?

27 DR. McCOY: It is a voluntary organiza-  
28 tion for doctors who meet certain standards for member-  
29 ship for general practitioners.

30 COMMISSIONER VAN WART: Medical Council  
of Canada?

DR. McCOY: The Medical Council of



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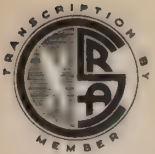
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of Canada?

DR. MCCOY: The Medical Council of





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4 Canada is a licensing body that grants a degree of  
5 Licenciante of the Medical College. I think this is a  
6 most important function.

7 COMMISSIONER VAN WART: They give  
8 routine examinations for acceptance into the practice  
9 of medicine?

10 DR. McCOY: Correct.

11 COMMISSIONER VAN WART: And the passing  
12 of this examination is accepted in the province?

13 DR. McCOY: Right.

14 COMMISSIONER VAN WART: The Royal  
15 College of Physicians and Surgeons; what is their rela-  
16 tion to the profession?

17 DR. McCOY: Well, this is a national  
18 organization you are referring to here and they are the  
19 qualifying body granting fellowship in certain specialties  
20 for the Dominion as a whole. It has no particular  
21 relationship to British Columbia as a province.

22 COMMISSIONER VAN WART: And has  
23 L'Association des Mediciens de Langue Francais du Canada any  
24 membership or activity in this province?

25 DR. McCOY: I do not know much about  
26 this. I think they have a Chapter in British Columbia,  
27 I think they have a Chapter in all provinces or nearly  
28 all provinces. They had a meeting here about three or  
29 four years ago and I believe they have very few members  
30 in British Columbia. They are not an active organization  
at all.

COMMISSIONER VAN WART: Now, coming to  
your brief specifically, on page 24, Section 81:

Canada is a licensing body that grants a degree of  
licensure of the Medical College. I think this is a  
most important function.

COMMISSIONER VAN WART: They give  
routine examinations for acceptance into the practice  
of medicine?

DR. MCCOY: Correct.

COMMISSIONER VAN WART: And the passing  
of this examination is accepted in the provinces?

COMMISSIONER VAN WART: The Royal  
College of Physicians and Surgeons; what is their rela-  
tion to the profession?

DR. MCCOY: Well, this is a national  
organization you are referring to here and they are the  
qualifying body granting fellowship in certain specialties  
for the Dominion as a whole. It has no particular  
relationship to British Columbia as a province.  
COMMISSIONER VAN WART: And has

L'Association des Medecins de Langue Francaise du Canada and  
memberships on activity in this province?

DR. MCCOY: I do not know much about  
this. I think they have a chapter in British Columbia.  
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all provinces. They had a meeting here about three or  
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COMMISSIONER VAN WART: Now, coming to

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"The financing of all hospital and Government laboratories should be undertaken on the basis of a budget formula".

Does that exist at the present time?

DR. WATSON: Mr. Chairman, the aspects of budget formula as to the running of a pathology department in a hospital is only in existence in one hospital in British Columbia at the present time; the rest are on the basis of salary and expenses of the operating costs.

COMMISSIONER VAN WART: Is it the practice of the hospitals to submit a budget to the Provincial Government at the beginning or before the beginning of the year so that their rate can be struck?

DR. WATSON: You mean those hospitals which are not on the budget formula?

COMMISSIONER VAN WART: Put it this way: does the Provincial Government require every hospital to have a budget?

DR. WATSON: Yes, certainly.

COMMISSIONER VAN WART: And is that budget submitted to the Provincial Government before the year of operation?

DR. WATSON: Yes, several months before.

COMMISSIONER VAN WART: And in laboratory, is the same thing done in the laboratory?

DR. WATSON: In all those hospitals, yes, in all of them really, even the one with a budget formula, although it has a little different arrangement



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yes, in all of them really, even the one with a budget  
Dr. Watson: In all those hospitals,  
tory, is the same thing done in the laboratory?

COMMISSIONER VAN WART: And in Japan?

Dr. Watson: Yes, several months

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budget submitted to the Provincial Government before the

COMMISSIONER VAN WART: And is that

Dr. Watson: Yes, certainly.

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COMMISSIONER VAN WART: But in this way?

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3 to be able to set its budget.

4 COMMISSIONER VAN WART: Then, on page  
5 35, Section 116, this deals with physical fitness.  
6 Does your Association think a plan of mass physical  
7 fitness in British Columbia, not just to train athletes,  
8 but physical fitness programs almost comprehensive in  
9 nature, covering all the population; have you given any  
10 consideration to that aspect of the physical fitness  
11 program?

12 DR. WATSON: We have a Committee on  
13 Physical Fitness which is part of our organization, and  
14 they are working very closely with the Canadian Associa-  
15 tion for Physical Fitness and Rehabilitation, or Recrea-  
16 tion, excuse me, to come up with - at the present they  
17 are looking to some of the facilities for research to  
18 find out what problems are presented in this aspect and  
19 to come up with some solution for it. We hope they will  
20 give us the report which will be able to then sponsor or  
21 stimulate a program of physical fitness for the whole  
22 population, not necessarily just athletic endeavours.

23 COMMISSIONER VAN WART: Your organization  
24 feels such a program is a necessity?

25 DR. WATSON: We feel it is a very impor-  
26 tant part of health care, yes. We actually stimulated  
27 this Committee to get these findings as soon as possible.

28 COMMISSIONER VAN WART: Would you say a  
29 physical fitness program would be one of the priorities  
30 on the medical care plan?

DR. WATSON: I am afraid we don't know  
enough about the local problems or the general problem

to be able to set its budget.

COMMISSIONER VAN WART: Then, on page

33, Section 116, this deals with physical fitness.

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3 to be able to answer that, Mr. Chairman. Certainly,  
4 personally, I feel it has a place in the needs of the  
5 Canadian people. I couldn't answer any more. If there  
6 is anyone else here who has different opinions, it might  
7 be of use to you.

8 COMMISSIONER VAN WART: Do you feel it  
9 is urgent enough and should be studied?

10 DR. WATSON: Yes, and we are studying  
11 it.

12 COMMISSIONER VAN WART: Thank you.

13 On page 86, Section 278, half-way down:

14 "We believe in the provision of partial  
15 time-loss benefits for the sick, not in  
16 such a way as to induce a desire to be  
17 ill, but in order to remove the added  
18 worry of impecunity and so on".

19 What do you mean by partial time-loss  
20 benefits? Can you explain that?

21 DR. WATSON: What we mean is an amount  
22 of money that would be less than the full wage or less  
23 than the amount which would have a tendency to induce  
24 people to remain in a disabled way.

25 COMMISSIONER VAN WART: Where would  
26 that money be available from?

27 DR. WATSON: Well, this could be - we  
28 haven't put all our thoughts down on this, but certainly  
29 it should be on the basis of expanded health benefits  
30 outside the field of prepaid medical care from insurance  
companies or possibly other non-profit groups that may be  
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4 COMMISSIONER VAN WART: Just one more  
5 question. It is in Kelowna brief on page 4, the green  
6 section. At the top of the page you have a breakdown  
7 of the remuneration of one of the clinics. It speaks  
8 about private accounts and non-approved plans, 49.79%.  
9 Like to do it now? Do you know if the Kelowna boys have -  
10 how much is private and how much is the other factor?

11 DR. WATSON: You mean whether that  
12 item has been broken down?

13 the present time. COMMISSIONER VAN WART: It is a very  
14 large item. It is the largest item under remuneration.  
15 I just wondered if the Kelowna boys had broken it down.

16 DR. WATSON: I don't believe there is  
17 anyone here I could call on. I believe Dr. Boyd has gone  
18 into this with the Kelowna people and he may give you  
19 some views on this.

20 DR. BOYD: I think the figure 49.79 is  
21 higher in Kelowna than would be the average across the  
22 province. Kelowna is a pleasant place on a lake with no  
23 industry and a lot of retired people. It is the home of  
24 our Prime Minister.

25 COMMISSIONER VAN WART: Retired?

26 DR. BOYD: It is a place - I think  
27 there would be less approved plans than you would find  
28 elsewhere. I think you might find that because the  
29 average income in Kelowna is higher than in many other  
30 places. There would be a tendency to have more private  
accounts and rather less approved plans.

As a guess I would say of the 49%, 10%  
would be non-approved plans or 10 of the 49, and the



COMMISSIONER VAN WART: Just one more

question. It is in Kelowna listed on page 4, the green section. At the top of the page you have a breakdown of the remuneration of one of the chiefs. It speaks about private accounts and non-approved plans, \$8,788.

Do you know if the Kelowna boys have -

how much is private and how much is the other kind?

DR. WATSON: You mean whether that

item has been broken down?

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would be non-approved plans or 10 of the \$8, and the



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3 other 39 would be private patients.

4 COMMISSIONER VAN WART: That is all.

5 THE CHAIRMAN: Dr. McCreary, I under-  
6 stand you are required to leave and there is a matter  
7 you would like to refer to before you leave. Would you  
8 like to do it now?

9 DR. MCCREARY: If I may, I would like  
10 to refer to the support of medical research in Canada  
11 about which a number of us are really very concerned at  
12 the present time. I think it has been abundantly proved  
13 that medical research is necessary for good medical  
14 training.

15 If we don't have the atmosphere in  
16 which research is going on the training is by rote and  
17 very quickly forgotten by the recipient.

18 We have in Canada five different  
19 federally-supported agencies that produce funds for  
20 medical research. They are the Medical Research Council;  
21 the Defence Research Board; the National Health Grant;  
22 the Department of Veterans' Affairs and the Queen Eliza-  
beth Fund.

23 These five provided this past year a  
24 fund of \$10.8 million for support of medical research in  
25 Canada. Of this amount \$3.6 million was spent in the  
26 Government laboratories and not distributed to the  
27 medical schools and hospitals. The remaining \$7.2 million  
28 was distributed widely to medical schools and hospitals  
across the country.

29 This sounds like a very significant  
30



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to refer to the aspect of medical research in Canada  
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the present time. I think it has been abundantly proved  
that medical research is necessary for good medical  
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3 amount. Certain things have happened in the United  
4 States in the last three years which are changing this  
5 picture really very drastically. The United States have  
6 a similar group of federally-supported agencies support-  
7 ing medical research that they classify together under  
8 the term National Institutes of Health.

9 Up until about three years ago the  
10 amount of money which they provided for the support of  
11 medical research was about \$250,000,000 a year. Of that  
12 \$250,000,000 they spent \$50,000,000 in their own govern-  
13 ment-sponsored laboratories, so there is approximately  
14 \$200,000,000 going to the medical schools and hospitals  
15 in the country.

16 In the last three years this fund has  
17 exploded with tremendous rapidity. Three years ago it  
18 went from \$250,000,000 to \$425,000,000. Last year it  
19 went up to \$650,000,000 and this year is \$890,000,000.  
20 This tremendous transfusion of funds into research pro-  
21 grams has produced certain problems in relation to  
22 medical education because medical schools are hiring  
23 people who are essentially free to do research, although  
24 really it means teaching tends to be down-graded.

25 The way in which it has affected us in  
26 Canada, sir, is rather serious. It produces more  
27 research opportunities than they have trained research  
28 people to fill and inevitably they are looking for  
29 researchers to come down and accept these positions that  
30 have been offered, and Canada is one of the places to  
which they look.

We have had one experience locally to

amount. Certain things have happened in the United States in the last three years which are changing this picture really very drastically. The United States have a similar group of federally-supported agencies supporting medical research that they classify together under the term National Institutes of Health.

Up until about three years ago the amount of money which they provided for the support of medical research was about \$150,000,000 a year. Of that \$150,000,000 they spent \$50,000,000 in their own government-sponsored laboratories, so there is approximately \$100,000,000 going to the medical schools and hospitals in the country.

In the last three years this total has exploded with tremendous rapidity. Three years ago it went from \$150,000,000 to \$425,000,000. Last year it went up to \$650,000,000 and this year is \$850,000,000. This tremendous transfer of funds into research programs has produced certain problems in relation to medical education because medical schools are hiring people who are essentially free to do research, although really it means learning tends to be down-graded. The way in which it has altered us in

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3 give you some idea of the difficulties that sort of  
4 research opportunity can provide. We have a man  
5 trained locally in pediatrics who went away to take two  
6 years further training in an American centre in pedia-  
7 trics. (faint text)

8 He was supported there for two years,  
9 Dr. Baltzan, under the Queen Elizabeth Fund. He  
10 returned to this Faculty last September at a salary of  
11 \$7,500 which was the standard salary we could offer to  
12 pay an instructor. Within two months of his return he  
13 was offered a job on a research project sponsored by  
14 N.I.H. in the school he received his training, at  
15 \$17,000 a year. He is leaving and he is going to go  
16 back down.

17 We are very concerned with this tremen-  
18 dous explosion of funds down there and the great opening  
19 up of research opportunities, not just in terms of  
20 salary, but in terms of facilities with which to do  
21 research and the opportunities to get good research done  
22 is going to drain our research population out of our  
23 Canadian schools unless we do something to make the  
24 opportunities somewhat more equivalent than they are at  
25 the present time.

26 Now, it takes about two years before  
27 this tremendous sum of money which has been granted down  
28 there really reproduces itself in terms of increased  
29 number of jobs. Really, what we are feeling now, is the  
30 benefit of the \$425,000,000 that was granted two years  
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5 have a rapid explosion of research funds as occurred in  
6 the United States. I think it could cause a series of  
7 complications. I am afraid it is urgent that we make  
8 some effort to equilibrate the opportunities in these  
9 two countries.

10 THE CHAIRMAN: To what extent would  
11 you say we should increase the \$10,000,000 a year?

12 DR. McCREARY: Well, sir, first of all  
13 I think the expansion in the research fund in Canada  
14 should go through the Medical Research Council which in its  
15 newly-formed set-up I think is going to be a very efficient  
16 organization. I think it would be fair to say there  
17 should be an increase of \$2,000,000 a year for five years.

18 I think any more than that we would  
19 have funds we couldn't adequately use. I think we could  
20 get our research opportunities to the level of  
21 \$2,000,000 each year for a period of that time and then  
22 we would have to review it again.

23 COMMISSIONER McCUTCHEON: What is more  
24 important, the level of salary or the opportunity to do  
25 research?

26 DR. McCREARY: I think the second is  
27 probably the more important. The Farquharson Report,  
28 as you will recollect, recommended making provision of  
29 resources in Canada to do research. This hasn't been  
30 implemented yet. We don't have laboratories or offices.  
We can't buy books. We can't do the things which are  
required for good research.

COMMISSIONER BALTZAN: Dr. McCreary,

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COMMISSIONER HARTMAN: Dr. McCRAE:





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3 would you mind repeating this? I cannot write as quickly  
4 as you talk. The first was the Medical Research Council,  
5 the second was D.V.A., the third, the National Health  
6 Grants and the fourth, the Queen Elizabeth Fund. What  
7 was the fifth?

8 DR. McCREARY: The Defence Research  
9 Board.

10 COMMISSIONER BALTZAN: The Defence  
11 Research Board. Dr. McCreary, have you any idea of the  
12 amount of private philanthropies?

13 DR. McCREARY: Yes, I could give you  
14 the round figures. It would amount to something less  
15 than 50% of the total government-supported medical  
16 research.

17 COMMISSIONER BALTZAN: Can you also,  
18 perhaps, state what industries are contributing to  
19 medical research?

20 DR. McCREARY: Well, I would think  
21 it is really grouped in the private philanthropies.  
22 I don't think industry today has produced a tremendous  
23 amount for the support of medical research.

24 THE CHAIRMAN: Thank you. Thank you  
25 very much, Dr. McCreary. Before you leave, I want to,  
26 on behalf of the Commission, thank you and also to publicly  
27 acknowledge our appreciation to you for the help you are  
28 giving the Commission, both in the University of British  
29 Columbia and as part of the medical education team.

30 DR. McCREARY: Thank you very much, sir.

THE CHAIRMAN: Dr. Strachan?

COMMISSIONER STRACHAN: Mr. Chairman, I

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DR. MCCREARY: Thank you very much, sir.

THE CHAIRMAN: Dr. Strachan?



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3 have two or three questions. The answer to the first,  
4 I hope will clarify the other questions.

5                     Gentlemen, I am sure that in the world  
6 in which we live together you recognize the fact that  
7 the term "doctor" is an extremely broad term. There are  
8 many doctors, learned doctors, outside the profession,  
9 the health profession, and certainly outside the medical  
10 field.

11                    Even in the health field the term  
12 "doctor" in its broadest sense is a limited term because  
13 there are many, many personnel without the Doctor degree  
14 in health services.

15                    However, I must conclude that in general  
16 your use of the term "doctor" is in its narrowest possible  
17 sense. In that way the term often becomes very confusing.  
18 My first question refers to page 6, paragraph 13, the  
19 summary:

20                    "Income tax relief be given to those  
21 doctors who attend post-graduate  
22 studies as part of keeping abreast of  
23 their work".

24                    Are you using this term now in its  
25 narrowest possible sense to which I have referred or do  
26 you refer to health personnel in general?

27                    DR. WATSON: Mr. Chairman, I accept  
28 Dr. Strachan's comments, and I realize how biased our  
29 view sounds as stated here. We do really feel that it  
30 is difficult to speak for everyone who might come within  
the field of a doctor in health facilities; the health  
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4 restrict this principle or the philosophy to just the  
5 medical profession. Certainly, if it is correct for  
6 the medical profession it is correct for any professional  
7 lay group who are involved in health services to keep  
8 abreast of their educational requirements.

9 Then, although we cannot speak for all  
10 of the people, certainly the philosophy is correct and  
11 we would certainly adopt that, Mr. Chairman.

12 COMMISSIONER STRACHAN: What do you  
13 mean here? Do you mean those physicians or do you mean  
14 those professional health personnel because you have  
15 certainly other doctors who are not in the medical or  
16 even the dental field but still in the health field?

17 DR. WATSON: As I said, we have restric-  
18 ted our thinking here to the medical profession because  
19 we have had to speak for the medical profession.

20 COMMISSIONER STRACHAN: Then you  
21 actually mean physicians?

22 DR. WATSON: In this context we do mean  
23 physicians, yes.

24 COMMISSIONER STRACHAN: If that is what  
25 you mean there, you have told the Chairman that in order  
26 the priorities are first, medical education and education  
27 of lay workers. Does that refer to education of physicians?  
28 Are there any others that you include in there between  
29 the terms of physicians and lay people at all; are those  
30 the two top groups to be considered in education?

DR. WATSON: I find it difficult to  
answer you without appearing to change the wording of  
the brief.



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4 COMMISSIONER STRACHAN: That isn't in  
5 the brief. Those are your own words. You told the  
6 Chairman medical education and education of lay workers  
7 has the first priority.

8 DR. WATSON: I feel we are thinking of  
9 all those persons who are involved in the rendering of  
10 health services there when we talk of medical education.  
11 We are certainly including those persons who are doing  
12 aspects of medical care that fall into the field of  
13 physics and into the field of industry and such.

14 I certainly feel that we are in a  
15 difficult situation if you wish us to speak for all these  
16 people. By the fact we have only spoken in one field,  
17 it does not mean that we are including or discounting  
18 these people.

19 COMMISSIONER STRACHAN: I am glad to  
20 have that assurance, sir.

21 DR. WATSON: Dr. McCoy might have an  
22 additional comment to make.

23 DR. McCOY: In trying to answer this,  
24 sir, Dr. Watson has made it clear that we, at the moment,  
25 are only speaking on behalf of the doctors.

26 COMMISSIONER STRACHAN: On behalf of  
27 the physicians, if you please?

28 DR. McCOY: On behalf of the physicians,  
29 that is right.

30 COMMISSIONER STRACHAN: I think we  
would understand each other better that way.

DR. McCOY: I think this recommendation  
13 could just as well have been written in view of our



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5 those taxpayers who attend postgraduate studies as part  
6 of keeping abreast of their work. This may enable other  
7 tax-paying people who take postgraduate work to keep up  
8 with their work. I think this would be a correct inter-  
pretation.

9 I have been in Ottawa with the Depart-  
10 ment, and I am sure this is what we believe here, that  
11 this would be correct.

12 COMMISSIONER STRACHAN: Thank you, Dr.  
13 McCoy.

14 There was one other matter that came  
15 to my mind this morning in speaking of the hospital ser-  
16 vice rendered to those men under Department of Veterans'  
17 Affairs. They naturally get their hospitalization in  
D.V.A. hospitals.

18 What arrangements are made for the  
19 families of those individuals? Have you any scheme by  
20 which they can get coverage?

21 DR. WATSON: The D.V.A. veteran who is  
22 cared for for a pensionable disability can receive care  
23 in D.V.A. hospitals by this, and if his pension, say, is  
24 20%, as soon as he is admitted to the hospital for care  
25 of this condition, his pension raises to 100%, which is  
an increased amount which might help his family.

26 As far as I know, there is no plan to  
27 take care of the dependents of this group, but when a  
28 veteran with a certain qualification of service becomes  
29 indigent or past a certain age group with indigent condi-  
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3 becomes qualified for what they call the War Veterans'  
4 Allowance, which gives him all his medical care at the  
5 D.V.A. hospitals, in-patient or out-patient, and his  
6 wife would be part of that scheme also.

7 Now, not many of these persons have  
8 dependents other than their wives, but there is no  
9 scheme that I know of, and I might ask Dr. Lehman if  
10 what I have said is entirely correct.

11 COMMISSIONER STRACHAN: I would heartily  
12 disagree with you that not many have dependents beyond  
13 their wives, because I think there is a large element  
14 of veterans who have young families today.

15 DR. WATSON: I am talking about the  
16 war veteran. This is the elderly one who was probably  
17 overseas in the First World War, and he is the only  
18 person that qualifies for this. And I might say they  
19 have no dependents.

20 THE CHAIRMAN: That is popularly called  
21 the "burnt-out pension"?

22 DR. WATSON: Yes, sir.

23 DR. LEHMAN: The wives of the veterans  
24 are not covered, nor does the wife of the recipient of a  
25 War Veterans' Allowance receive any medical care from  
26 D.V.A.

27 COMMISSIONER STRACHAN: That is the  
28 reason I am asking the question. Have you any scheme  
29 under M.S.I. for those wives and families?

30 DR. LEHMAN: No. They would be eligible  
-- I just don't know where they get care. They would not  
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care. I would think it must come from the community.

5 DR. BLAIR: If I may, most of these  
6 individuals are covered by existing plans because they  
7 are working individuals even though they are covered by  
8 the D.V.A. for their medical costs, and most of their  
9 dependents are covered by M.S.A., etc.

10 DR. LEHMAN: He is talking about reci-  
11 pients of War Veterans' Allowance.

12 DR. WATSON: They could qualify for  
13 social assistance medical service on income and age  
aspects. Several of them have.

14 In my own practice, I have two that  
15 qualify by the fact that they are retired from employment  
16 that gave them prepayment prior to retirement, and this  
17 is carried on in the retirement phase. The wife of this  
18 burnt-out pensioner would be carried on that type of  
coverage.

19 COMMISSIONER STRACHAN: Thank you, Mr.  
20 Chairman.

21 COMMISSIONER FIRESTONE: Dr. Watson,  
22 your brief contains a very important principle as far as  
23 your attitude towards medical care and health services  
24 in the Province of British Columbia is concerned.

25 May I quote this principle to you and  
26 ask you to elaborate? I am quoting from paragraph 264  
on page 81. You say, sir:

27 "Financial security against the total  
28 cost of allowance is our end",  
29 the end being that of your Association.  
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ask you to elaborate. I am quoting from paragraph 284

on page 81. You say, sir:

"Financial security against the total

cost of illness is our end,

the end being that of your association.



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3 That is your main objective?

4 DR. WATSON: Yes.

5 COMMISSIONER FIRESTONE: Now, sir, how  
6 do you plan to provide that financial security? Do you  
7 have in mind a prepayment approach to providing that  
8 financial security?

9 DR. WATSON: Other aspects than medical  
10 costs, you mean?

11 COMMISSIONER FIRESTONE: Well, sir, we  
12 are referring here, sir, to what you have said. You  
13 speak here of financial security against a total cost of  
14 allowance. How do you plan to provide that financial  
15 security against the total cost of allowance?

16 My question is: do you have in mind a  
17 prepayment plan to provide this financial security you  
18 are talking about?

19 DR. WATSON: No. I must say we do not  
20 feel that we are offering or can offer a plan that will  
21 cover the total costs of illness from all aspects, such  
22 as sick time loss away from work, drugs, or other aspects,  
23 such as dentistry. We have not proposed this, no.

24 COMMISSIONER FIRESTONE: Well, sir,  
25 would you then explain to me what you mean by saying  
26 that your aim is financial security against the total  
27 cost of illness?

28 DR. WATSON: Well, I would think that  
29 it is a term that we have used rather loosely that you  
30 have taken. What you mean is that from the point of view  
of the cost; the medical costs involved in an illness, if  
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3 many persons, that this all adds to the financial security  
4 as a person goes through a serious illness.

5 We certainly hope that other groups  
6 who will help in this field and join with us in the  
7 aspects that they can take care of.

8 COMMISSIONER FIRESTONE: In other words,  
9 your overall objective is financial security against the  
10 total cost of illness, but when it comes to developing a  
11 plan you quite rightly say "We are concerned with a  
12 medical plan because we are members of the medical profes-  
13 sion". But you are making these proposals against an  
14 overall objective, and the overall objective is stated  
15 here -- am I correct in that understanding -- and the  
16 overall objective being financial security against the  
total cost of illness?

17 DR. WATSON: Yes, I think that this is  
18 our view that we feel this is the goal that should be  
19 pressed towards.

20 COMMISSIONER FIRESTONE: This is the  
goal and you support that goal?

21 DR. WATSON: Yes.

22 COMMISSIONER FIRESTONE: Thank you, sir.  
23 Now, you feel that you can achieve this in the medical  
24 field through a system of prepayment?

25 DR. WATSON: Right.

26 COMMISSIONER FIRESTONE: Do you feel  
27 that this system might be extended to other fields of  
repayment?

28 DR. WATSON: Yes, we do.

29 COMMISSIONER FIRESTONE: I understood  
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DR. WATSON: Yes, we do.

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COMMISSIONER FIRESTONE: Do you feel

DR. WATSON: Right.

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3 from you that you would be in favour of other programs  
4 to be developed to provide prepaid health services  
5 besides medical care services, and presumably this  
6 would include in addition to hospitalization, which is  
7 already in existence, other programs such as prepaid  
8 dental care, prepaid nursing care, and prepaid drug care  
9 and another, let us call it, a layman's group of health  
10 services.

11 Would you be in favour of such a  
12 broad approach to achieve the objective which you stated  
13 in the beginning?

14 DR. WATSON: Yes. Our experience in  
15 this field is such that we feel this is a very good way  
16 to approach these problems.

17 COMMISSIONER FIRESTONE: And you would  
18 feel that each different group concerned with a certain  
19 aspect of health services should develop their own plan  
20 so that we might have in Canada and in British Columbia  
21 not just one health care plan but perhaps half-a-dozen  
22 health care plans in hospitalization, in dental services,  
23 in drug services, and so on?

24 DR. WATSON: It is our feeling that  
25 this is a more accurate way of doing it, a more specific  
26 way, so that these persons who are interested in this,  
27 and who are more experienced in it, can actually handle  
28 this type of program and not be involved in things that  
29 they are not expert at or not correct in.

30 COMMISSIONER FIRESTONE: In other words,  
your proposal is based on the reasoning that this would  
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COMMISSIONER FINESTONE: In other words, your proposal is based on the reasoning that this would be a more efficient system to have half-a-dozen systems



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3 in the field of health services rather than one system?

4 Is that your point?

5 DR. WATSON: It is our thinking, yes.

2 6 COMMISSIONER FIRESTONE: The thinking  
7 being that it would be more efficient because it would  
8 be administered by people that know something about a  
9 particular subject?

10 DR. WATSON: That is right.

11 COMMISSIONER FIRESTONE: Well, would  
12 it not be possible to visualize a system that covers  
13 all the health services with people expert in their  
14 respective fields administering each part of it within  
15 an overall program, instead of running six different  
16 programs?

17 DR. WATSON: Yes, I could visualize  
18 this if certain particulars were drawn out beforehand.  
19 Yes, this does not really seem to differ much more to  
20 what I had in mind.

21 COMMISSIONER FIRESTONE: If you  
22 could visualize it, would you support such a program  
23 whereby a prepayment program of different health services  
24 would be brought together within one framework, with  
25 people from the respective professions participating in  
26 each section, within a general framework but under one  
27 umbrella, under one head, under one organization,  
28 instead of having six organizations or sixty?

29 DR. WATSON: I think our acceptance of  
30 this would depend on the particulars of organization of  
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3 where the authority of each group started or finished.  
4 Of course, it would depend on the terms.

5 COMMISSIONER FIRESTONE: Well now, can  
6 I be of a little help to you and spell this out? You  
7 are quite right to say it would depend on the terms.  
8 But let us assume there was a scheme in operation that  
9 would finance all the health services concerned that are  
10 covered, from contribution by those who can afford it  
11 out of their own resources and by those who cannot  
12 afford it, by the State.

13 So the sources of funds would come  
14 from the two sources: funds by those who can afford it  
15 out of their own resources, and for those who cannot  
16 afford it, from the State. That would be the source of  
17 funds.

18 And, secondly, the administration would  
19 be one group, one umbrella, that would take care of all  
20 these half-a-dozen plans. Would you be in favour of  
21 such an arrangement?

22 DR. WATSON: I think this fits in  
23 fairly closely to our ideas. As you stated, I think it  
24 would be something we would be interested in and in  
25 favour of.

26 COMMISSIONER FIRESTONE: In the interest  
27 of providing the best possible care at the lowest possible  
28 cost to the patient?

29 DR. WATSON: Yes, I think so.

30 COMMISSIONER McCUTCHEON: May I  
interrupt? I understood you earlier to say, Dr. Watson,  
that you believed in a variety of competitive plans so

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3 that people could choose the particular plan that was  
4 suited to their individual purpose? If I have lost my  
5 teeth and I have a good set of dentures, I might not  
6 want to go into a plan to provide dental services.  
7 Would you treat it from that view?

8 DR. WATSON: No. When you say that  
9 there is a group of different organizations that would  
10 be interested in one aspect of rendering health service,  
11 this, in my mind, does not limit you to obtaining your  
12 services from any special dentist or any special doctor.

13 COMMISSIONER McCUTCHEON: No, no. Are  
14 you saying -- you said you wanted a variety of plans so  
15 that people could make their choice as to the type of  
16 plan that suited their individual requirements.

17 Now, are you retreating from that view,  
18 or do you still want a variety of medical plans, let us  
19 say?

20 DR. WATSON: I would say that this is  
21 still our aim, that we have enough variety for people  
22 to choose from.

23 COMMISSIONER McCUTCHEON: Well, that  
24 is right. Thank you.

25 COMMISSIONER FIRESTONE: You are still  
26 adhering to the principle that you are interested in a  
27 program and in plans that will give the people medical  
28 care services at the lowest possible cost and of a  
29 standard which the medical profession approve. That is  
30 your basis?

DR. WATSON: That is a general aim,  
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4 COMMISSIONER FIRESTONE: We appreciate  
5 that, and as you realize, sir, we are not in a position  
6 to go into every detail. We have to deal with particular  
7 objectives and general principles. When it comes to the  
8 implementation, there are many complexities involved,  
9 and it would take us more than a short period of time to  
10 cover all these aspects. We accept that.

11 But, to come back to the point we are  
12 discussing, I take it from what you are saying that if  
13 a multiplicity of schemes has the effect of raising  
14 costs to the patient, and the patient will have to pay  
15 more for his medical care service than other health  
16 services, that your own preference would be to develop a  
17 scheme that would provide these services at the most  
18 efficient and most economical basis to the patient within  
19 the requirements of providing high quality service  
20 acceptable to the medical profession?

21 DR. WATSON: Well, this is a long,  
22 involved question that seems to surmise things. First  
23 of all, our aim is to get security for the people in  
24 their taking care of illness, and this does not neces-  
25 sarily mean that we are interested in getting them the  
26 cheapest cost, or what might not be the most efficiently  
27 administered type of assistance or help, and if you then  
28 say that if a multiplicity of plans is going to increase  
29 the costs or make it cost more to the patient to obtain  
30 this, then we have to be sure that this is the case  
before we answer. I mean, I cannot say if this is the  
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not been our experience that this is the case, that when





COMMISSIONER FIRSTONE: We appreciate

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4 there is competition and when there is an availability  
5 of different types of plans for the person that they  
6 can choose one more satisfactory to their needs, and  
7 maybe therefore with less cost to them than one which  
8 was presented to them as a holus bolus plan.

9 COMMISSIONER FIRESTONE: May I quote  
10 to you from the British Columbia Medical Journal, May,  
11 1960, page 319, a statement that has been made by the  
12 Trans-Canada Medical Plans, and I quote:

13 "The administrative costs of private  
14 agencies could be lowered by government  
15 programs with a profit base and in  
16 competition".

17 Do you disagree with the statement by  
18 the Trans-Canada Medical Plan?

19 DR. WATSON: Well, I certainly have  
20 not heard any evidence that would substantiate that. I  
21 would disagree with it.

22 COMMISSIONER McCUTCHEON: You do not  
23 know the context from which the statement is taken either,  
24 Dr. Watson.

25 DR. WODEHOUSE: Are we talking about  
26 Trans-Canada Medical Plans, because I have a more  
27 national connection, as you know. I think I agree with  
28 Mr. McCutcheon that we do not know the full context of  
29 the statement and I think we have to say that the simpli-  
30 city of administration, possibly the reduction of overall  
costs, is only one feature. You want quality, you want  
competition, you want variation and many of these things  
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4 I think without knowing the reason  
5 which you quote there that will be implied somewhere.

6 COMMISSIONER FIRESTONE: This was a  
7 useful contribution and I suggest you consider it and  
8 you have ample opportunity to present this to us at the  
9 national hearing on this point.

10 Now, to go back to you, Dr. Watson,  
11 in this sentence which we have been discussing you speak  
12 of financial security against the total cost available;  
13 what do you have in mind in the phrase "total cost"?

14 DR. WATSON: Well, we have in mind the  
15 aspects that enter into taking care of a sick person such  
16 as hospitalization, medical care, drugs, facilities to  
17 obtain these, such as ambulances and things of this  
18 nature.

19 As I said before I think that you have  
20 quite rightly taken this point of view that we are well-  
21 informed and are going to be able to tell you all of  
22 these aspects and I am afraid we are not able to do this  
23 for you. This is the philosophy which we hold and which  
24 we are not necessarily capable of rendering every detail  
25 or every plan that might be available in which we see  
26 illness as much more than just medical costs; we see it  
27 in many other aspects in our own practice and we feel  
28 this way of looking at illness must be realized by  
29 people or they are going to obtain perks to help them  
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4 experienced and knowledgeable in fields other than  
5 medical care services. Would it be appropriate, there-  
6 fore, to ask you what you have in mind when you speak  
7 of covering the total cost of medical care services?  
8 Presumably this is your field?

9 DR. WATSON: Well, we have in mind  
10 having people obtain medical services on what we have  
11 been talking about as a comprehensive basis. We appre-  
12 ciate the inaccuracy of that word, that it is not  
13 completely comprehensive, but we feel that we have gone  
14 a long way to making it very helpful to people. There  
15 are very few things that are restricted that are excep-  
16 tionally important and we intend, if we can, to even  
17 extend these.

18 COMMISSIONER FIRESTONE: You, in para-  
19 graph 170 on page 50, have given us a definition of  
20 comprehensive services and you have excluded under compre-  
21 hensive services such things as a medical check-up. Is  
22 it true that people over 40 are encouraged to have  
23 medical check-ups, maybe a few years more or less but  
24 something of that order?

25 DR. WATSON: I think that many state-  
26 ments to that effect have been made by various people,  
27 yes.

28 COMMISSIONER FIRESTONE: Would you  
29 yourself and your associates support this as a desirable  
30 medical practice?

DR. WATSON: I would say a person who  
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3 have routine physical check-ups within every year or two  
4 years after the age of 40, yes.

5 COMMISSIONER FIRESTONE: This is fair  
6 and I take it if you are aiming to provide a plan that  
7 covers a total cost of medical care services why do you  
8 want to exclude things which you yourself on medical  
9 grounds consider desirable?

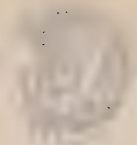
10 DR. WATSON: We do not wish to exclude  
11 them, we have agreed to have them excluded for other than  
12 good medical reasons. We are attempting, at the present  
13 time, and have for some time, to introduce the routine  
14 physical check-up as part of our prepaid care. This is  
15 a co-operative effort between the non-profit societies  
16 and ourselves and it always ends up with a bit of give  
17 and take on the part of both parties when a decision is  
18 reached.

19 COMMISSIONER FIRESTONE: In setting  
20 yourself a target I quoted a statement of yours as an  
21 objective; I take it this has not achieved this objective  
22 you are aiming at, a program which will be comprehensive  
23 enough to eliminate all the exclusions you have in para-  
24 graph 170? Am I right in this being your objective?

25 DR. WATSON: That is our aim, we  
26 certainly intend to try that.

27 COMMISSIONER FIRESTONE: In other words,  
28 when you say you are in favour of a comprehensive medical  
29 care plan you recommend that coverage be given to all  
30 medical care services which, in the opinion of the profes-  
sion, are in the interests of the patient?

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DR. WALTON: Yes.





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4 COMMISSIONER FIRESTONE: With no  
5 exclusions?

6 DR. WATSON: That is true.

7 COMMISSIONER McCUTCHEON: You would  
8 not exclude cosmetic surgery any more?

9 DR. WATSON: No, I think there has  
10 been enough information obtained that this sometimes  
11 has a very beneficial effect on the patient themselves.  
12 That is a point on which further information could be  
13 given.

14 DR. McCOY: In trying to answer Dr.  
15 Firestone's question; first, the small detail about  
16 the physical examinations: our statement is that financial  
17 security against total cost of illness and a general  
18 physical examination is not interpreted as an illness in  
19 the first place.

20 We have been taking this as our point  
21 of view throughout our brief on the basis of gradually  
22 increasing the amount of our coverage. We hope one day  
23 to cover general examinations but this is in the preven-  
24 tive field, you are not covering costs of actual illness.

25 You can provide anything that people  
26 want to pay for but if you are going to get the costs of  
27 a general check-up which might cost in the vicinity of  
28 \$10 a year, you will raise the share of practically  
29 everybody in the plan because they will take it and  
30 that means costs will go up 80¢ a month.

We are caught between trying to keep  
our costs low enough so people can afford it and providing  
enough care so if people want to spend another 80¢ a

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3 month then that can be provided. That is what we are  
4 working towards generally.

5 In answer to Professor Firestone's  
6 question about financial security against total cost of  
7 illness; if I could attempt to answer this in a slightly  
8 different way: it is rather important that we do not  
9 expect to provide all this financial security, we are  
10 doing what we can to provide the medical care costs.

11 B.C.H.I.S. provides the service at  
12 approximately 50¢ of the medical dollar and we think the  
13 medical care costs are approximately 20¢ of the dollar  
so if we get this extra it is 70¢ of the dollar.

14 In our province any firm, anybody who  
15 wishes, can buy provision for many of these so-called  
16 extended health benefits, the extra benefits from insu-  
17 rance plans and we do not think we should put the insu-  
18 rance companies out of business. That is available to  
19 the people of our province if they wish to buy it but  
20 we do not necessarily think we should do all of the  
21 financial security against the cost of illness. Does  
this answer your question?

22 COMMISSIONER FIRESTONE: Yes, thank  
23 you very much. May I just ask a specific question; does  
24 your Association support a plan which will include  
25 services connected with preventive medicine? The answer  
is either yes or no.

26 DR. WATSON: Yes.

27 DR. MCCOY: Yes.

28 COMMISSIONER FIRESTONE: I detected  
29 some observations that suggested "Well, let the fellow  
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month then that can be provided. That is what we are

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4 pay for his check-up himself because it is part of preven-  
5 tive medicine", but if you are in favour of a program  
6 which excludes preventive medicine then obviously some  
7 arrangements have to be made. Are you in favour of that?

8 DR. WATSON: We are of the opinion  
9 that the routine physical check-up is a routine part of  
10 medical care and we will try to get it if we possibly  
11 can and we have not any doubt that we will be able to.

12 THE CHAIRMAN: We will recess now  
13 until 2 o'clock.

14 --- Luncheon adjournment.  
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--- LUNCHEON adjournment.





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4 --- On resuming at 2 p.m.

5 THE CHAIRMAN: Ladies and gentlemen,  
6 if we can come to order, we will proceed.

7 COMMISSIONER BALTZAN: Dr. Watson, if  
8 we may turn now to the hospitalization scheme as it is  
9 now in operation in British Columbia. Does the B.C.  
10 Medical Association support the scheme as it now exists?  
11 Do you find it adequate and satisfactory?

12 DR. WATSON: We find that the scheme  
13 that was set up is a great improvement over the previously  
14 existing condition as far as hospital care is concerned.  
15 Through experience we have found that the one aspect of  
16 the inflexibility of financial arrangements has a great  
17 part to play in controlling some of the extension of  
18 services and extension of some of the new aspects of  
19 medical care which are available now, which weren't  
20 available when the system was set up or as it was admini-  
21 stered. I don't think we can state that we have any  
22 major objection to it. We feel that it is quite a good  
23 service and performs a great - fills a great need for  
24 the people of the province.

25 COMMISSIONER FIRESTONE: If you are  
26 asked whether you have any specific suggestions as to  
27 how this system can be improved, have you such specific  
28 suggestions?

29 DR. WATSON: One of the suggestions  
30 would be that a more realistic attitude would be that  
the Board of Directors of hospitals who are set up to be  
autonomous, should have control, should have some method of  
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5 In other words, one that is tied in  
6 with so many other departments which need funds which  
7 are not available for spreading too wide. In other words,  
8 we think hospital care of a special nature requires more  
9 flexibility than might be given by a government depart-  
10 ment.

11 COMMISSIONER FIRESTONE: Sir, is it  
12 your proposal that government financing of the hospitaliza-  
13 tion program should be based on the actual operating  
14 costs of hospitals rather than on predetermined budgets that  
15 may have no direct relationship to actual operating  
16 costs?

17 DR. WATSON: Yes, with a responsible  
18 organization running the hospital and with advice from  
19 groups that overlook several hospitals that could have a  
20 perspective. There should be some arrangement of  
21 receiving funds for specific hospitals when they know  
22 their situation and type of work that goes on and their  
23 location.

24 COMMISSIONER FIRESTONE: Does the  
25 present system permit this?

26 DR. WATSON: I would say no. I would  
27 say that the present system is so difficult to change  
28 that it is always behind the situation. You may improve  
29 something which should have improved two or three years  
30 ago and before you have got that changed you have another  
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6 year. At the moment there is a loophole. There is an  
7 escape hatch.

8 COMMISSIONER FIRESTONE: When these  
9 adjustments are made, do they take account of the full opera-  
10 ting cost of the hospital?

11 DR. BELL-IRVING: Yes, they do that.  
12 You forecast.

13 COMMISSIONER FIRESTONE: I take it, sir,  
14 you are operating on an adjustment that covers the year  
15 past?

16 DR. BELL-IRVING: That is right.

17 COMMISSIONER FIRESTONE: Therefore,  
18 these adjustments either take care of the total expense  
19 of the operation of the hospital or it doesn't?

20 DR. BELL-IRVING: It does, sir.

21 COMMISSIONER FIRESTONE: In other  
22 words, there are no hospital deficits?

23 DR. BELL-IRVING: Oh yes there are, sir.

24 COMMISSIONER FIRESTONE: How could  
25 there be hospital deficits if the total operating costs  
26 have been taken care of by the Government?

27 DR. WATSON: I would like to say in  
28 my opinion the deficit may be absorbed by the hospital  
29 service if they wish to, if they have agreed it is a  
30 valid extension of service or a valid deficit. They  
may take care of this. There is no guarantee. Certainly,  
no hospital in B.C. has gone bankrupt because of this.  
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4 COMMISSIONER McCUTCHEON: None have  
gone bankrupt yet?

5 DR. WATSON: Yet.

6 COMMISSIONER FIRESTONE: But the empha-  
7 sis which you are placing, if I understand you correctly,  
8 is that the system as it now operates is not adequate  
9 enough to take care of the total operating costs of the  
10 hospitals, particularly in the light of innovations, new  
11 services and many other things that progress in medicine  
brings?

12 The question I would like to put to  
13 you, Dr. Watson, and your colleagues: if this is the  
14 situation, how can that situation be improved so account  
15 would be taken of these new developments and the total  
16 operating cost would be taken care of for the service  
17 they contribute to its advancement?

18 Sir, that may be a difficult question.  
19 If this question, in all its ramifications, has not been  
20 considered by your executive, I would be quite happy that  
21 it be considered further and you could give us your  
22 considered views as to what actually should be done, in  
practice, to improve the operation of this system.

23 DR. WATSON: I would ask anyone that  
24 has any views to state them. We have discussed this.  
25 It is something we have discussed many times. As I  
26 said previously, the main point that we feel is that  
27 the Government supplying funds to operate the hospital  
28 should have more faith in the persons who are running it,  
29 to realize that there are specific situations of various  
30 hospitals which receive identical funds when compared to

COMMISSIONER McCUTCHON: None have

gone bankrupt yet?

DR. WATSON: Yes.

COMMISSIONER FIRESTONE: But the empha-

sis which you are placing, if I understand you correctly, is that the system as it now operates is not adequate enough to take care of the total operating costs of the hospitals, particularly in the light of innovations, new services and many other things that progress in medicine

The question I would like to put to

you, Dr. Watson, and your colleagues: if this is the situation, how can that situation be improved so account would be taken of these new developments and the total operating cost would be taken care of by the service they contribute to its advancement?

Sir, that may be a difficult question.

If this question, in all its ramifications, has not been considered by your executive, I would be quite happy that it be considered further and you could give us your considered views as to what actually should be done, in practice, to improve the operation of this system.

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3 another hospital of possibly the same number of beds.

4 DR. BOYD: Might I add to this? One  
5 of things you are concerned about is quality of service,  
6 quality of control. Frequently, from the medical aspect,  
7 new developments are growing and we would like to see  
8 these developed in whatever hospital we are working in.

9 In fact, we are losing the race. We  
10 are competing with other centres in other parts, parti-  
11 cularly the south. We are losing the race. One way  
12 this could be controlled, if the Board of Trustees of  
13 hospitals were convinced this new service was essential  
14 to good quality control, they could raise their per diem,  
15 co-insurance. Then the public would know when they had  
a good hospital and when they didn't.

16 There would have to be a differential.  
17 There is a fixed co-insurance factor in this province  
18 which keeps the hospitals at the same level.

19 DR. BANKS: I was going to amplify  
20 that point. I was just going to say the trouble is at  
21 the present time there is no budgetary flexibility because  
22 the money is coming from one source with the exception of  
23 a small amount coming from private beds and things like  
that.

24 Perhaps it would be of advantage in  
25 providing flexibility if the Boards of hospitals could  
26 get money from alternative sources. One of the possible  
27 alternative sources that has been considered, I believe  
28 by the Government as well as the Hospital Boards, is the  
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29 THE CHAIRMAN: Is this the only way you  
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4 feel the system could be improved or can you visualize  
5 an improvement of the administrative arrangement as it  
6 exists, which includes budgeting as well as assessment  
7 of the amounts which are reasonable operating costs and  
8 what are not?

9 DR. BANKS: I couldn't answer that, sir.  
10 I think the administration has to be judged by the  
11 various hospitals because the care given in various  
12 hospitals varies widely. All we are asking for is a  
13 little flexibility.

14 COMMISSIONER FIRESTONE: That is an  
15 honourable objection. All I am trying to understand is  
16 how this could be achieved. We are here to advise the  
17 Canadian Government as to improving the existing system.  
18 Surely we can have some help from the people directly  
19 involved?

20 THE CHAIRMAN: We might expect that  
21 from the people who operate the hospitals when they  
22 appear before us.

23 COMMISSIONER FIRESTONE: I would hope  
24 we would get some from them. I was wondering whether  
25 the medical profession, who is directly involved,  
26 couldn't help us.

27 DR. BELL-IRVING: Yes sir, we have in  
28 mind Section 4, the Board of Administrative Research.  
29 The way we have developed medical skill and knowledge  
30 has been through research and the methods of research.  
We have depended on initial initiative and drive to  
come from the individual. In this case it would be indi-  
vidual hospitals, but we have given them the method

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the way to get some from them. I am not sure  
how our third party, the medical profession, can help  
us have decided that the medical profession is to  
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4 whereby they can come through research projects and  
5 the same methods could be applied with great benefit,  
6 I think, to hospitals.

7 We have services run on a proper  
8 research basis. It is just when the people have such a  
9 project in mind they have a body to come to, a source  
10 of money to carry out research and independent valuation  
11 of this. This, we feel, would be an appropriate way to  
12 fulfil any change in administration. It would have to  
13 come from proper research methods, not just be imposed.

14 ~~responsibility of~~ COMMISSIONER FIRESTONE: You were  
15 saying perhaps one method would be to increase the one  
16 dollar a day contribution made by individual patients.  
17 How do you look at that one dollar a day? Do you look  
18 at it as co-insurance, a deterrent? How do you see it?

19 DR. BANKS: This is what we would  
20 prefer to call patient participation in the cost of  
21 illness. The word "deterrent", and this is not just  
22 merely semantics, is a word we don't like to use. We  
23 don't like to deter people from necessary medical care.

24 ~~very sensible~~ COMMISSIONER FIRESTONE: In other  
25 words, you look at it as co-insurance, participation in  
26 payment, not as a deterrent? You generally are against  
27 deterrents as far as medical care services are concerned  
28 and hospital services are concerned?

29 DR. BANKS: This brings up the whole  
30 question perhaps of cost control, and this problem which  
is, perhaps, the crux of the payment for medical services  
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4 a foolproof answer.

5 Let us go through some of the possible  
6 alternatives. Surely the crux of the problem of paying  
7 for medical insurance is the question of utilization?  
8 If it is necessary utilization, this is fine, but perhaps  
9 it might be, in some cases, over-utilization.

10 This brings right into focus the  
11 whole question of over-utilization because it is tied  
12 to increasing costs. This again translates itself into  
13 responsibility of the doctor and patient. How can the  
14 responsibility of the doctor and the patient best be  
15 insured, and, of course, there are many methods of doing  
16 this.

17 In our own prepayment plan we like to  
18 consider that responsibility can be kept at the level of  
19 premium. If utilization increases, premiums go up.

20 Now, there are disadvantages in doing  
21 this in our present plan. The utilization of a group  
22 goes up because of certain individuals. This might be  
23 very laudable if that individual is really sick, but  
24 sometimes, perhaps a certain group of individuals in this  
25 group have over-utilized.

26 The premium can always be utilized as  
27 a method of cost control. It is unwieldy administratively  
28 and therefore we turn on, as all Canada has turned, our  
29 attention to the bringing in of the responsibility factor  
30 at the level of service.

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5 ineffective. I think we have a T.C.M. report to show  
6 it is an ineffective deterrent. We are generally  
7 against deterrents because if you have to pay a deterrent  
8 of, say, \$25 that is incurred before insurance is paid  
9 it is a considerable amount to some people.

10 Therefore, we don't like a lump sum  
11 deterrent. This brings us around to the question that  
12 perhaps a patient could be asked to pay a percentage of  
13 the cost. Here is your point with the hospitalization.  
14 Shall this percentage be just a straight sum as it is  
15 in the hospitalization or shall it be a small percentage  
16 of the cost? How could it be done?

17 In the field of medical care, sir,  
18 there is an opinion this could be done by what we call  
19 the reimbursement principle whereby the patient is billed  
20 against a published fee schedule; I emphasize that point,  
21 against a published fee schedule, by his doctor and is  
22 reimbursed for 90% of the cost.

23 The advantage of this, sir, is that  
24 it cuts down on possible doctor abuse. We would be  
25 very unrealistic to say there was no doctor abuse at the  
26 present time. There is a small percentage. It underlines  
27 the patient's responsibility. It doesn't put a crippling  
28 burden on the patient.

29 Of course there are some difficulties.  
30 It is unpopular because it increases the work of some  
of the doctors. I don't think it would be unpopular too  
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In the field of medical care, sir, there is an opinion this could be done by what we call the reimbursement principle whereby the patient is billed against a published fee schedule; I emphasize that point, against a published fee schedule, by his doctor and is reimbursed for 80% of the cost.

The advantage of this, sir, is that it cuts down on possible doctor abuse. We would be very unrealistic to say there was no doctor abuse at the present time. The patient's responsibility. It doesn't put a crippling burden on the patient.

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4 I am being very long-winded, but I am  
just trying to help.

5 COMMISSIONER FIRESTONE: You have been  
6 very helpful, Dr. Banks. As I understand it, sir, you  
7 and your associates are against the principle of a deter-  
8 rent payment in the provision of medical care service?

9 DR. BANKS: Against a lump sum set-terent.

10 COMMISSIONER FIRESTONE: Are there  
other kinds of deterrent?

11 DR. BANKS: Yes sir.

12 COMMISSIONER FIRESTONE: Would you  
13 explain what such deterrents would be you would be in  
14 favour of?

15 DR. BANKS: We are trying to get away  
16 from the word "deterrent" which is a lump sum. You  
17 might say we consider patient participation, the patient  
18 entering the responsibility with the doctor into the cost  
of his illness.

19 COMMISSIONER FIRESTONE: Let us there-  
20 fore explore what you call patient participation. How  
21 would patient participation, as you visualize it - is  
22 there any comprehensive medical care scheme which, accor-  
23 ding to your object, would cover the title, cost of bonus,  
24 and I am limiting it now as far as the medical profession  
is concerned.

25 DR. BANKS: What we said, sir, was  
26 that we should give security against the total cost.  
27 Now, we did not mean the whole total cost should be paid,  
28 because this is where you get into difficulty. When the  
29 Government or an employer pays the whole premium, the  
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6 and the patient because it is important for the doctor  
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8 as it is important for the patient not to be able to  
9 call the doctor out to his house many times.

10 We feel that this could be done by  
11 the patient in some way paying, as I say, a small percen-  
12 tage -- a percentage that must not go, as it does in  
13 some parts of the world, too high to the actual cost at  
the level of service.

14 I believe if you go into this in great  
15 detail, as I know you have, it will be apparent that the  
16 only workable way is the reimbursement principle.

17 COMMISSIONER FIRESTONE: Is this what  
18 your Association recommends?

19 DR. BANKS: Sir, what we recommend is  
20 that we be given flexibility for experimentation. You  
21 ask us; you put us in the position of a scientist  
22 engaged in a tremendous experiment of social research,  
23 and you ask us to tell you what we are going to recommend  
24 in ten years' time when we have all these results. We  
25 do not know this yet. It looks, at the present time,  
as if this might be a practical way.

26 We beseech you to give us time before  
27 we can attempt to answer, and if you say, gentlemen,  
28 you have no time, somebody is going to make a decision  
29 in this field right now, there is going, perhaps, to be  
30 a marriage of government and doctors. If this is to be



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4 shot-gun marriage, I think, sir, that on this solemn  
5 occasion, the right dress for us to be wearing would be  
6 a reimbursement shirt.

7 DR. WATSON: You will understand now  
8 why I have let Dr. Banks go on.

9 COMMISSIONER FIRESTONE: He is eloquent,  
10 but I think Dr. Banks also realizes that this Commission  
11 is called upon to prepare a report for the Government of  
12 Canada dealing with the points that have been raised,  
13 and we cannot defer our report for ten years or the time  
14 you mention it may require to experiment. We are trying  
15 to gain by your experience, and get the best judgment  
16 we can get from you.

17 Now, if we could get that in the next  
18 few months, all right, but not over a longer period of  
19 time.

20 THE CHAIRMAN: Or even to see what the  
21 offspring of this marriage will look like!

22 COMMISSIONER FIRESTONE: Exactly, sir.

23 You will understand we do require some  
24 views from you within reason, whatever you consider  
25 practical to give us now, or at a later time, if you want  
26 to consider the matter and let us know in writing, we  
27 will be very happy.

28 We are interested in your views, and  
29 not in a quick answer if it is not readily available.

30 DR. WATSON: Surely, sir.

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4 will be financed. "Do you visualize financing it the way  
5 it is done now, and as I understand it there is no co-  
6 insurance, or is there? "Would you like to elaborate?"

7 DR. BANKS: No, sir, there is not.

8 COMMISSIONER FIRESTONE: How are we  
9 understand the proposal; that co-insurance be introduced?  
10 Do you feel the existing system is not adequate or effec-  
11 tive?

12 DR. BANKS: Last year, we were exploring  
13 the ways and means whereby we could set up a pilot plan  
14 to introduce such a scheme. "Let me again underline the  
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16 tion like M.S.I. paying for the insurance and an organiza-  
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27 Therefore, it sometimes occurs that  
28 the money is not forthcoming for some years, perhaps,  
29 and then we find that the services, both hospital services  
30 and doctor services, are being done on a shoestring.

31 COMMISSIONER FIRESTONE: Well, sir, if  
32 I may come back to the question I have asked earlier. "Do

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I may come back to the question I have asked earlier. Do



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3 you support a plan without contribution by the individual  
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5 continue with a plan as you now have it under M.S.I.  
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7 That is the question.

8 COMMISSIONER McCUTCHEON: The indivi-  
9 dual pays the total cost today.

10 COMMISSIONER FIRESTONE: Well, Doctor?

11 DR. WATSON: We feel that the liaison  
12 between our prepaid plans is such that we are quite  
13 willing to carry on without reimbursement factor. We  
14 do feel, however, that experience we have had in social  
15 assistance medical health services and our indirect  
16 services through hospital care that we would not wish to  
17 tie ourselves to a government-sponsored plan without  
18 the flexibility that reimbursement would allow us. It  
19 is not necessarily a selfish idea, but an idea we feel  
20 that if costs are allowed to increase without any method  
21 of controlling them right at the present time, that the  
22 service will get to a point where the quality of the  
23 care has to be reduced to stay within the bounds of the  
24 limits of the budget, and this is something we are afraid  
25 of.

26 We do not wish to put the people of  
27 Canada nor ourselves in that situation, and I would think  
28 that this Association feels that if government is going  
29 to supply the greater percentage of the money to run a  
30 medical scheme, we do want a reimbursement factor intro-  
duced into the scheme.

DR. McCLURE: It would be fair to say





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Canada nor ourselves in that situation, and I would think

that this association feels that if government is going

to supply the greater percentage of the money to run a

medical scheme, we do want a reimbursement factor intro-

duced into the scheme.

DR. McCLELLAN: It would be fair to say



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4 that if we were to extend it province-wide, that if it  
5 is going to cover everybody in the province, we would  
6 still like the reimbursement principle.

7 COMMISSIONER FIRESTONE: I take it  
8 from what you say that you have given consideration to  
9 how a government-sponsored scheme might operate? You  
10 have made reference to it several times. Have you  
11 visualized the sort of scheme you could be willing to  
12 co-operate with?

13 DR. WATSON: We have certainly  
14 considered the aspect of government entering into it.  
15 I do not really feel that we have everything lined up  
16 for the Government to do so. Sir, you might tell me in  
17 what respect you want to question me on that.

18 COMMISSIONER FIRESTONE: That is a very  
19 fair observation, sir, and thank you.

20 As I understand it, the principle  
21 which you suggested to us is those who can afford to pay  
22 for such prepaid medical services do so, and those who  
23 cannot pay, the State should pay for it. Therefore, if  
24 I understand you correctly, you envisage a scheme which  
25 would be partly privately financed and partly State  
26 financed; is that correct?

27 DR. WATSON: That is correct.

28 COMMISSIONER FIRESTONE: Can we examine  
29 somewhat the aspect of the State-financed system? When  
30 you speak of a State-financed system, are you talking in  
terms of a provincial government-financed plan, a federal  
government-financed plan or a combination of the two?

DR. WATSON: I think we are being

that if we were to extend it province-wide, that it is going to cover everybody in the province, we would still like the reimbursement principle.

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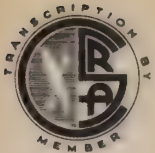
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3 realistic in the fact that we feel that it will be the  
4 two; that the Federal Government and the Provincial  
5 Government will share in these costs.

6 COMMISSIONER FIRESTONE: And you  
7 would feel that perhaps the experience that has been  
8 gained in the federal-provincial corporation in the  
9 hospitalization field might be applied, with appropriate  
10 modification, to the medical care services here?

11 DR. WATSON: This is not against our  
12 thinking. We are not quite as expert in this field as  
13 you might think, but these are our ideas about it.

14 COMMISSIONER FIRESTONE: We are just  
15 interested, really, in your ideas, sir, and you are  
16 experienced in your own field.

17 Now, as you know, the Federal Government  
18 contributes 50%, approximately 50%, to the hospitalization  
19 program. Would such a contribution to a provincially-  
20 operated medical care plan be in line with your thinking?

21 DR. WATSON: Sharing costs would be in  
22 line with our thinking, yes.

23 COMMISSIONER FIRESTONE: Would 50% be  
24 on the high side or the low side, or within what you are  
25 thinking of?

26 DR. WATSON: I do not think we have any  
27 ideas on it other than the fact that sharing the costs  
28 would be advisable.

29 DR. McCLURE: We only picture a 50%  
30 participation in the province. This would be different  
if it was 100% who are participating in a government-  
sponsored plan, because the 50% would be very much greater



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3 than 15% of 50%.

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6 COMMISSIONER FIRESTONE:

7 You have suggested to the Commission  
8 that those who can afford to pay for medical care  
9 services do so, and those who cannot, have their premium  
10 or equivalent paid by the State, and then I proceeded to  
11 ask you who would that be and suggest a federal-provin-  
12 cial government, or 50-50 share, as we have in the  
hospitalization field would be acceptable?

13 DR. WATSON: Yes. I cannot see any  
14 reason to object to the percentage. That really is not  
15 our concern.

16 DR. LEHMAN: I do not think the question  
17 of which proportion the Federal or Provincial Government  
18 would make is any concern of ours. We are concerned  
19 about dominant participation and we do not draw a  
distinction between one or the other.

20 COMMISSIONER FIRESTONE: But you are  
21 interested in this payment being made by the Government  
22 and if the Province of British Columbia would say unless  
23 they get a 50% contribution from the Federal Government  
24 they will not be prepared to do so, this would affect  
you very directly?

25 DR. LEHMAN: Not us. I think it would  
26 affect the plan.

27 COMMISSIONER FIRESTONE: It would  
28 affect those who would be treated by you, and who other-  
29 wise would have to pay for it?  
30





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COMMISSIONER FIRESTONE: It would  
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wise would have to pay for it?



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4 DR. LEHMAN: I would not want us to be  
in a position of being advocates of this.

5 COMMISSIONER FIRESTONE: But you are in  
6 favour of payment for those who cannot pay it for them-  
7 selves?

8 DR. LEHMAN: Yes.

9 COMMISSIONER FIRESTONE: You must,  
10 therefore, be advocating some means of paying for it.  
11 Perhaps we can continue on this question of how this  
12 can be paid for and who is really involved.

13 I think you, sir, suggested approxi-  
14 mately 15% of the population of British Columbia. Are  
15 you suggesting, sir, that this covers all the indigent  
16 and medically indigent people in the Province of British  
Columbia?

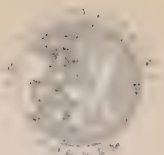
17 The 15% would amount to about 270,000  
18 people, roughly?

19 DR. WATSON: 1,600,000.

20 COMMISSIONER FIRESTONE: About 270,000  
21 persons. So, you are saying that the total medically  
22 indigent population, including the indigent in the social  
23 welfare class, number about 270,000 people; is that  
correct?

24 DR. WATSON: This is similar to this  
25 morning, when I talked about comprehensive. Our idea  
26 of an indigent is a person who is indigent because of  
27 financial aspects. You might call it Mr. Chairman's  
28 term "medically uninsurable". That might be what you  
mean by medically indigent.

29 COMMISSIONER FIRESTONE: No. We accept  
30



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in a position of being advocates of this.

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3 your definition. We are talking of 270,000 persons.

4 DR. WATSON: The indigent person is  
5 the low income person, and by our evaluation, which is  
6 an arbitrary choice, as I said this morning, of \$2,000  
7 and \$3,000 income in the family. We feel that 15% of  
8 the people in the province fall within this income  
9 level or income bracket, and we feel they need assistance.

10 We may be wrong. It may be a group  
11 higher than that need assistance, when this is gone into  
12 more carefully.

13 COMMISSIONER FIRESTONE: This is,  
14 again, a very fair observation. You are a very helpful  
15 witness. You are saying to the best of our knowledge  
16 something like 270,000 are what you and I call "medically  
17 indigent", but if our surveys show there are more people  
18 in that group, we have no objection that they be covered  
19 as well?

20 DR. WATSON: Not at all.

21 COMMISSIONER FIRESTONE: This is very  
22 helpful, sir, because if one were to judge your proposal  
23 as it stands, with the arbitrary cut-off, you may run  
24 into a lot of cases where people earn more than \$60 a  
25 week, and people that are just unable, because they have,  
26 perhaps, five or six children, they are just unable to  
27 pay. Therefore, your suggestion would be, if I under-  
28 stand you correctly, that this 270,000 number of popula-  
29 tion is a minimum figure, and that the figure may turn  
30 out to be somewhat larger on examination. Is that what  
you say?

DR. WATSON: Yes. I would like to say

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DR. WATSON: Yes. I would like to say



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3 we have chosen this type of income just from our own  
4 practical knowledge of the persons we work with. We  
5 have then tried to find out where these people are in  
6 the province and how many there are, and in this way we  
7 have tried to be specific for you, but certainly the  
8 philosophy behind it is that if people are in need of  
9 assistance we want them to have it, and we want them to  
10 have such assistance as they need to accomplish this  
11 task.

12 COMMISSIONER FIRESTONE: And you would  
13 provide that assistance on what basis? Just the income  
14 basis, or would you want to have a means test?

15 DR. WATSON: Well, as Dr. Banks pointed  
16 out to you this morning, we feel that a means test is a  
17 fair way of establishing need, if it is done with the  
18 idea of obtaining the facts and truth about the case,  
19 and we have also felt that the people in the province  
20 have agreed with this, and those number of persons are  
21 not necessarily those who have prepayment already, or  
22 who did not have prepayment, nor are they of the high  
23 income group only. They are of the majority of persons  
24 who consider that a means test is a fair way of establishing  
25 financial need.

26 COMMISSIONER FIRESTONE: Well, sir,  
27 was this survey taken covering a cross-section of popula-  
28 tion in all income groups?

29 DR. WATSON: I could say this, and I  
30 would like to ask Mr. McCort to tell you, because he has  
the figures.

MR. McCORT: The survey was taken on a





we have chosen this type of income just from our own practical knowledge of the persons we work with. We have then tried to find out where these people are in the province and how many there are, and in this way we have tried to be specific for you, but certainly the philosophy behind it is that if people are in need of assistance we want them to have it, and we want them to have such assistance as they need to accomplish this task.

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DR. WATSON: I could say this, and I

would like to ask Mr. McGee to tell you, because he has the figures.

MR. MCGEE: The survey was taken on a



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3 representative basis. That is, probability sample.  
4 There was no attempt to get people within certain income  
5 groups. The only way a survey may be made projectable  
6 to the population as a whole is to take it totally on a  
7 probability basis.

8 Therefore, all chances are that the  
9 income groups representative are actually the income  
10 groups in British Columbia.

11 COMMISSIONER FIRESTONE: This was a  
12 random sample?

13 MR. McCORT: This was a random sample;  
14 totally random sample, yes.

15 COMMISSIONER FIRESTONE: And therefore,  
16 by definition, likely representative of different  
17 income groups?

18 MR. McCORT: That is correct.

19 COMMISSIONER FIRESTONE: And what was  
20 the result of those saying they had no objections to the  
21 means test?

22 MR. McCORT: This was about 88%.

23 COMMISSIONER FIRESTONE: Well now, sir,  
24 this included people that are in the very low income  
25 groups that would be affected by the means test. Accord-  
26 ing to what you have given us, you have suggested 85%  
27 that are not in this group, and therefore would include  
28 the 15% you feel are in this group, plus the 85% which  
29 are not in this group.

30 Would you not say, as an expert in the  
field, if you had taken a sample only of the people  
involved in the income group you are talking about, the

representative basis, that is, probability sample.  
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the 12% you feel are in this group, plus the 88% which  
are not in this group.

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field, if you had taken a sample only of the people

involved in the income group you are talking about, the





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3 15%, that this answer you get would have yielded an  
4 entirely different percentage and would have perhaps  
5 reflected the true situation of those that are involved  
6 that have to undergo a means test?

7 MR. McCORT: No. Homogeneity of  
8 income groups with respect to this question was very,  
9 very great. The answer in almost every income group was,  
10 in addition to 80%; 80% or above. This includes those  
11 people with the incomes which we are referring to in  
12 the 15%.

13 COMMISSIONER FIRESTONE: Have you had  
14 a separate compilation of people in incomes of \$2,000  
15 or less and \$3,000 or less as defined in here, and what  
16 was the percentage of those respondents in that income?

17 MR. McCORT: I have it here, Mr. Chair-  
18 man, if you would not mind waiting for one moment.

19 Mr. Chairman, I have the results here  
20 in income groups A, and income group A were those people  
21 living in households with incomes of \$2,000 or less.  
22 Those indicating approval towards the means test were  
23 88%. This varied from the others to a very, very small  
24 degree.

25 COMMISSIONER FIRESTONE: How many house-  
26 holds in this sample of low income group?

27 MR. McCORT: Again, I would have to  
28 look that up.

29 DR. WATSON: There was a total of  
30 2,500 households surveyed.

MR. McCORT: All income groups.

COMMISSIONER FIRESTONE: I am just





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3 concerned with the lower income groups.

4 DR. BANKS: I think the alternative is  
5 interesting and that is; surely if you are not going to  
6 give money where it is needed and in some way assessing  
7 the need, you have to give it to everybody?

8 COMMISSIONER FIRESTONE: There seem  
9 to be some people who are proposing this.

10 DR. BELL-IRVING: I might say the need  
11 has long been recognized in this province, both for  
12 social assistance and service for veterans; it is a well-  
13 understood thing and I have not had anybody turn it down.

14 COMMISSIONER FIRESTONE: It is difficult  
15 to turn down a means test if that is the only way you are  
16 going to get your service paid for.

17 DR. BELL-IRVING: You are getting quite  
18 a bit for it and it is a protection for the taxpayer.

19 MR. McCORT: 15.1% of the total survey  
20 of 2,539 people, roughly 375 were included in this - 375  
21 households.

22 COMMISSIONER FIRESTONE: Thank you  
23 very much. Could I also ask you to read into the record  
24 the question that was asked so we understand?

25 MR. McCORT: One cannot take it out of  
26 context because it is not as meaningful as it could be.

27 THE CHAIRMAN: Where are you reading  
28 from?

29 MR. McCORT: The special submission  
30 at page 45. As I point out, this is taken out of context  
and this was asked of people with no coverage and asked  
of people with inadequate coverage:





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"Now, suppose a plan were introduced in which everyone was covered. Most families paid all the monthly premiums. Those who were unable to afford the premiums could avoid payment by submitting to a 'means test' designed to prove inability to pay. Would you approve or disapprove of this 'means test'?"

Then, of course, after saying "approve" or "disapprove" they were asked why they said that.

COMMISSIONER FIRESTONE: We appreciate the only way somebody can answer or agree that he is in favour of a means test is because of the way the question was worded. This is the only way to avoid having to pay the premium.

MR. McCORT: It was not the only way.

COMMISSIONER FIRESTONE: Read the reference to "avoid".

MR. McCORT: "Those who are unable to afford the premiums could avoid payment by submitting to a means test ---"

COMMISSIONER FIRESTONE: In other words, if you have not the money because you are in a lower income group the only way you can avoid paying is to subject yourself to a means test. Now, if you are in an income group making \$40 or \$50 a week you have not got the money and the only way you can avoid paying it is to undergo the means test. What else can you say? That is the only way you can avoid paying. I am not suggesting



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the opposite.

MR. WOOD: It was not the only way.  
COMMISSIONER FIRESTONE: Read the

no extent to "avoid".

MR. WOOD: "Those who are unable to  
afford the premium could avoid payment by submitting to  
a means test."

COMMISSIONER FIRESTONE: In other

words, if you have not the money because you are in a  
lower income group the only way you can avoid paying is  
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4 this is not a justified question, I am just suggesting  
5 to you that it would be very difficult the way the  
6 question is worded to answer in any different way unless  
7 they belong to this small minority which have the conviction "I don't know where the money is coming from", but  
8 they still do not favour a means test.

9 I am suggesting the way the question is  
10 worded it throws doubt on the result.

11 THE CHAIRMAN: That may be so for you  
12 but I would not take that view. I do not think you are  
13 expressing the Commission's view, that is a personal view.

14 COMMISSIONER FIRESTONE: You are quite  
15 right; we are all here and if we are expressing any views,  
16 of course, we do so on our own. I am suggesting to you  
17 the way the question has been worded it introduces a  
18 bias in the answer and I would be very happy if you have  
19 other views so we can understand your views on this point  
20 much better.

21 MR. McCORT: If I understand correctly  
22 what you are stating, you feel that a man making \$50 or  
23 \$60 a month may feel - you say he feels he cannot; in  
24 other words, he goes beyond the \$2,000 but he still feels  
25 he cannot pay. Actually this is a matter of judgment  
26 because some people, with a salary over and some people  
27 with a salary under \$2,000 have come to the conclusion  
28 that medical care is more important to them than some  
29 other things they could spend money on.

30 This may be slightly biased but I  
cannot see it and it is not as biased as you say.

COMMISSIONER FIRESTONE: As long as you



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2 to you that it would be very difficult the way the  
3 question is worded to answer in any different way unless  
4 they belong to this small minority which have the conviction  
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14 right; we are all here and all we are expressing are views  
15 of course we do not want to be biased. I am not  
16 biased in the answer and I would be very happy if you have  
17 other views as we can understand your views on this point  
18 with interest.  
19  
20 MR. HODGKIN: I do understand correctly  
21 what you are saying. You feel that a man making \$20 or  
22 \$30 a month may feel - you say he feels he cannot, in  
23 other words, he goes beyond the \$2,000 but he still feels  
24 he cannot pay. Actually this is a matter of judgment  
25 because some people, with a salary over and some people  
26 with a salary under \$2,000 come to the conclusion  
27 that medical care is more important to them than some  
28 other things they could spend money on.  
29 This may be slightly biased but I  
30 cannot see it and it is not as biased as you say.  
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32 COMMISSIONER FINESTONE: As long as you



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4 suggest it could be slightly biased. Of course, there  
5 are degrees of bias.

6 May I come to another subject, and  
7 that is the subject of drugs. As you are aware there  
8 are numerous complaints that people are saying drug  
9 costs are too high. Would you say it is as a result of  
10 some of these complaints that perhaps physicians encounter  
11 from time to time, you also encounter the cases where  
12 people find it difficult to purchase a drug that has  
13 been prescribed by the physician for financial reasons.

14 DR. WATSON: I can only say from my  
15 own experience that I have had several cases, I would say  
16 in my memory there are four or five, where I have been  
17 informed by the drugstore that Mrs. So-and-So or Mr.  
18 So-and-So did not get their prescription because they  
19 found out it was too expensive.

20 In evaluating those cases I would say  
21 probably one of them I cannot understand why that was.  
22 It may be so that other persons have done this in my own  
23 practice which I have not been informed of. I have been  
24 in practice 11 years now and it has not been a major  
25 complaint that I have heard from patients or druggists  
26 that they have not been able to buy because of cost.

27 COMMISSIONER FIRESTONE: What does  
28 happen if some person cannot afford to pay? I am told  
29 some of the newer drugs are very expensive and a physician  
30 would say "Well, you need this drug, I am sorry it is  
expensive but it will help you"?

31 COMMISSIONER BALTZAN: Do you give  
32 some of these people the samples you have?





suggest it could be slightly biased. Of course, there are degrees of bias.

May I come to another subject, and that is the subject of drugs. As you are aware there are numerous complaints that people are saving drug costs are too high. Would you say it is as a result of some of these complaints that perhaps physicians encounter from time to time, you also encounter the cases where people find it difficult to purchase a drug that has been prescribed by the physician for financial reasons.

DR. WATSON: I can only say from my own experience that I have had several cases, I would say in my memory there are four or five, where I have been informed by the drugstore that Mrs. 82-and-80 or Mr. 80-and-80 did not get their prescription because they found that it was too expensive.

In evaluating these cases I would say probably one of them I cannot understand at that time. It may be so that other persons have done this in my own practice which I have not been informed of. I have been in practice 12 years now and it has not been a major complaint that I have heard from patients or druggists that they have not been able to pay because of cost.

Suppose if some person cannot afford to pay, I am told some of the lower drugs are very expensive and a physician would say "Well, you need this drug, I am sorry it is expensive but it will help you?"

COMMISSIONER BALLMAN: Do you give

some of these people the samples you have



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4 DR. WATSON: I was going to mention  
5 that. We heard some discussion about doctors' cupboards  
6 being loaded with drugs and samples and I find very  
7 frequently, I would say four or five times a day, that  
8 I go to my reducing cupboard, not being loaded up because  
9 it is going down, and then I am able to give persons who,  
10 in my opinion, may find hardship in paying for a prescrip-  
11 tion, enough of a drug to help them.

12 I quite agree there are many conditions  
13 where this is all right but many times there is a person  
14 with rheumatoid arthritis or some other condition and  
15 they need long-standing care. These people, of course,  
16 have social assistance and this is in the old-age group  
17 and they have this special arrangement with the doctor  
18 and the provincial pharmacy to obtain these.

19 COMMISSIONER FIRESTONE: What about the  
20 medical indigents, where are they going to get the drugs  
21 from? Would you suggest they should rely on doctors'  
22 samples?

23 DR. WATSON: I would say in my experience  
24 they somehow buy them.

25 DR. LEHMAN: Of course, there are also  
26 the societies like the Arthritic Society and I think in  
27 all fairness to some druggists I have on occasion called  
28 a druggist and he has agreed to supply it at wholesale  
29 cost because of the worthwhile things that have been  
30 prevented.

31 COMMISSIONER FIRESTONE: I take it a  
32 problem exists for providing adequate drugs for many of  
33 the patients that come to your office and perhaps some



DR. WATSON: I was going to mention

that. We heard some discussion about doctors' encounters

being loaded with drugs and samples and I find very

frequently, I would say four or five times a day, that

I go to my visiting cupboard, not being loaded up because

it is going down, and then I am able to give persons who,

in my opinion, may find benefit in paying for a prescrip-

tion, enough of a drug to help them.

I quite agree there are many conditions

where this is all right but when there is a person

with substantial addiction to some other condition and

then needs long-acting care. These people, of course,

have special assistance and this is in the older group

and they have this special arrangement with the doctor

and the pharmaceutical company to obtain them.

DR. WATSON: What about the

medical ingredients, when are they going to see the drugs

from which you suggest they should rely on doctors?

samples?

DR. WATSON: I would say in my experience

they are not there.

DR. WATSON: Of course, there are also

the situation like the British Section and I think in

all relations to these things I have on occasion called

a druggist and he has agreed to supply it at wholesale

cost because of the unusual things that have been

overruled.

DR. WATSON: I take it a

problem exists for providing adequate drugs for many of

the patients that come to your office and perhaps some





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system should be evolved to look after this?

DR. WATSON: I agree and I am pleased you are going along this line because it is important. When you are in practice and running across people all the time it amazes you the number of times people talk about these things and it has not been my experience that my patients have told me of the hardship they have in buying prescriptions recommended for them.

COMMISSIONER FIRESTONE: Have you run into complaints of patients that drug costs are too high?

DR. WATSON: Specifically to me, no, but I have had them say "My goodness, drug costs are high, are they not?"

COMMISSIONER FIRESTONE: Would you be in favour of a study to assess why drug costs are high?

DR. WATSON: Very much.

COMMISSIONER FIRESTONE: May I now turn to the last series of questions that concern themselves with the possible development of a federal-provincial medical care plan? If such a plan were conceived and in order to be helpful to you I would like to address these questions to you in stages and deal with each aspect. I see Dr. Banks is smiling because he has sat at some earlier meetings where these have come up and he has probably briefed you.

May I deal with it point by point?

DR. WATSON: I might say I have been present too.

COMMISSIONER FIRESTONE: This makes it so much easier for everybody concerned and, as I say, I





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4 welcome the fact that both you and Dr. Banks have been  
5 present at previous studies so we can have your  
6 considered view of these matters rather than a sort of  
hurried answer.

7 As I said at the beginning, we are  
8 very much interested in your views on what such a program  
9 of federal-provincial and other groups might involve.

10 May I start out by saying that within  
11 the federal framework such as we have in Canada one  
12 contribution which the Federal Government can make is a  
13 financial contribution. If the Federal Government were  
14 prepared to say, it was prepared to contribute 50% to a  
15 comprehensive medical care plan in Canada - and I am  
16 going to elaborate some of the conditions of that program  
17 as I go along but earlier you said you did not care very  
18 much whether it was 50% or 40% or 60% as long as it was  
a significant federal contribution. Is that your position?

19 DR. WATSON: I think we feel as long as  
20 a contribution is made by a government source to those  
who need it.

21 COMMISSIONER FIRESTONE: I take it  
22 from your answer that you would be in favour of the  
23 Federal Government making a contribution to a provincially-  
24 administered plan?

25 DR. WATSON: I would say we have no  
26 objection to them doing it but I still do not understand  
27 your point in feeling that the medical profession has  
28 some great influence as to whether it comes from federal  
or provincial.

29 If you could explain to me why you think  
30



without the fact that you and Mr. Barker have been  
present. I would studies so we can have your  
considered a lot of these matters rather than a sort of

As I said at the beginning, we are  
very much interested in your views on what such a program  
of federal-provincial and other groups might involve.  
May I start out by asking that within

the federal framework such as we have in Canada one  
contribution which the federal government can make is a  
financial contribution. If the federal government were  
prepared to say, it was prepared to contribute 50% to a

contribution we would, come plan in Canada - and I am  
going to elaborate some of the considerations of that program  
as I go along but here you said you did not have any  
such whether it was 50% or 60% or 80% as long as it was

a significant federal contribution. Is that your position?  
Dr. WALTON: I think we feel as long as

a contribution is made by a government source to have  
the plan.

Dr. WALTON: I think it  
is not your view that you would be in favour of the

unilateral plan?

Dr. WALTON: I would say we have no  
objection to them doing it but I still do not understand  
your point in saying that the medical profession has  
some great influence as to whether it comes from federal  
or provincial.

If you could explain to me why you think



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3 this is such an important point I may be of more help to  
4 you.

5 COMMISSIONER FIRESTONE: It is not a  
6 question of influence or no influence; obviously the  
7 medical profession has a great stake in a medical care  
8 plan and anything they have to say is of help to us and  
9 since we are concerned in finding things out for the  
10 Federal Government, we would like to have your assistance  
11 as to whether a federal contribution would be desirable.

12 Now, you can say you have no views and  
13 I accept that but we are here trying to help the Federal  
14 Government and would like your views as to whether they  
15 should make a contribution.

16 DR. WODEHOUSE: Is Commissioner Fire-  
17 stone talking about the 15% for the medically indigent  
18 or the 100% of population?

19 THE CHAIRMAN: I think that is a fair  
20 question.

21 COMMISSIONER FIRESTONE: I appreciate  
22 your attempt to help your colleague.

23 THE CHAIRMAN: I do not think there is  
24 anything wrong with that and I do not think there is any  
25 suggestion of that, they are just asking for clarification  
26 of the question.

27 DR. McCOY: I was about to ask the same  
28 question with one further breakdown. Commissioner Fire-  
29 stone was talking about a plan but by a plan does he refer  
30 to one organization, one plan, or an overall plan that  
might include several organizations within its overall  
plan. Is he speaking of a federal contribution to one



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I accept that but we are here trying to help the Federal  
Government and would like your views as to whether they  
should make a contribution.

Mr. WHEELER: As Commissioner First-  
Stone talking about the act for the medical indigent  
in the 1907 of the act.  
Mr. CHAMBERLAIN: I think that is a fair  
question.

Your attempt to help your colleagues.  
Mr. CHAMBERLAIN: I do not think there is  
anything wrong with that and I do not think there is any  
suggestion of that, they are just asking for clarification  
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Mr. MCCOY: I was about to ask the same  
question with one further breakdown. Commissioner First-  
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3 scheme - I am trying to get away from "plan" as a double  
4 meaning.

5 DR. LEHMAN: He has said a provincially-  
6 administered plan and I do not think we can break through  
7 this barrier because we do not accept that.

8 DR. MCCOY: We had in mind that the  
9 administration would be carried out by existing plans  
10 and it would be far nicer for our patients to go to the  
11 same plan as everyone else did.

12 THE CHAIRMAN: Dr. Firestone is asking  
13 you to forget all about that and start over fresh with  
14 his question. There is no other way of dealing with it.

15 DR. MCCOY: That is fair enough if we  
16 know what the question is.

17 COMMISSIONER FIRESTONE: That is the  
18 whole purpose of questioning, to establish what the  
19 question aims at and to give as reasonable an answer as  
20 is possible.

21 Dr. Watson, my question relates to  
22 whether the Federal Government would make a contribution  
23 to a provincially-administered plan leaving it up to the  
24 province to decide what would be an appropriate plan,  
25 to set certain minimum standards of what those plans  
26 should cover.

27 In other words, accepting the premise  
28 which you have suggested in your brief, those that can  
29 afford to pay for medical care services can do so and  
30 those that cannot pay for it should have their services  
paid for.

Now, this payment has to come from

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3 somewhere and I have been trying to establish where this  
4 payment should come from; the Federal Government, the  
5 Provincial Government or where? As I understand it you  
6 have no objections for the financing to come from both  
7 sources of Government?

8 DR. WATSON: That is right.

9 COMMISSIONER McCUTCHEON: As I under-  
10 stand it, I think he has said that three times; you are  
11 not necessarily advocating that it come from any parti-  
12 cular source of government?

13 DR. WATSON: We are not advocating that  
14 the Government is the only person to offer this assistance  
15 to the people who need it but I must admit that we cannot  
16 quite see any other body that could do it.

17 COMMISSIONER McCUTCHEON: You are not  
18 advocating that the Federal Government necessarily contri-  
19 bute; all you want is some government?

20 DR. WATSON: That is true.

21 DR. McCOY: Are we agreed that Commis-  
22 sioner Firestone is talking about the 15% in our plan or  
23 everyone?

24 COMMISSIONER FIRESTONE: I have dealt  
25 with this point already but I will be happy to restate it  
26 if it helps you. I have said we are concerned here with  
27 the people that are unable to finance their medical  
28 service because of inadequate income; whether it is 15%  
29 or 50% I do not know. I have said earlier that I feel  
30 we would not want to discuss figures, we are more  
concerned with the number and I feel that Dr. Watson has  
been very fair when he said the figure could well be



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COMMISSIONER MONTGOMERY: You are not  
advocating that the Federal Government necessarily contri-  
bute; all you want is some government?

MR. WATSON: That is true.

Someone else is talking about the 50% in our plan or  
everyone?

COMMISSIONER FLETCHER: I have dealt  
with this point already but I will be happy to restate it  
if it helps you. I have said we are concerned here with  
the people that are unable to finance their medical  
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or 50% I do not know. I have said earlier that I feel  
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4 higher and he was mainly concerned with the principle  
5 and my question relates to this principle.

6 Now, Dr. Watson, the point has been  
7 made that you are not concerned which government pays;  
8 you are mainly concerned that payment be made but if a  
9 provincial government finds it impossible because of the  
10 large amounts of funds involved would you feel that the  
11 Federal Government contribution is desirable?

B/dpw  
12 DR. WATSON: We would certainly feel  
13 if the province needs assistance the Federal Government  
14 would be the correct body to offer this assistance to  
15 them.

16 COMMISSIONER FIRESTONE: May I turn  
17 then to the next point? As I said earlier, the quickest  
18 way to wind up the questioning is to deal with it stage  
19 by stage.

20 Now, I suggested that such a program  
21 might be province-wide administered, or by the province  
22 administered, with the province deciding who belongs to  
23 this group of people, how much money is involved, how  
24 should it be paid to whom? Would you agree that any  
25 such federal set-up, such a scheme, would be most properly  
26 administered by the Provincial Government?

27 DR. WATSON: I would say that the  
28 information needed to administer such a scheme as we  
29 are advising here, advised earlier, requires that the  
30 Provincial Government be the administrative body to run  
it. A great deal of it has already come into existence  
with very little assistance or very little administration  
help from the Provincial Government.



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it. A great deal of it has already come into existence

with very little assistance or very little administration





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4 We are not, however, discounting the  
5 possibility that they have the right to any help in  
6 administration.

7 COMMISSIONER FIRESTONE: What would  
8 you say, sir, if the Provincial Government of the  
9 Province of Alberta approached M.S.I. and said "Are you  
10 prepared to administer such a scheme for us; you are  
11 familiar with the patterns, you are doctor-sponsored,  
12 you have the medical profession on your Board, you know  
13 the ins and outs"; would you support an arrangement  
14 whereby the Provincial Government might ask M.S.I. or  
15 M.S.A. to become the designated carrier?

16 DR. WATSON: If the province went to  
17 M.S.A. and M.S.I. and said "We would like to give you  
18 the funds to administer prepaid insurance to these people  
19 that need it", we would certainly feel that this is a  
20 reasonable attitude on their part and we would not object  
21 to it.

22 COMMISSIONER FIRESTONE: You would  
23 support a plan where the Provincial Government of the  
24 Province of British Columbia might use M.S.I. or M.S.A.  
25 as a designated carrier?

26 DR. WATSON: Working in the field that  
27 we have described to you, yes.

28 COMMISSIONER FIRESTONE: Now, sir, the  
29 Federal Government, before it could make any federal  
30 contribution, would have to set certain regulations such  
as basic standards of medical care service on a comprehen-  
sive basis available to everybody in the province irres-  
pective of age, pre-existing condition, occupational

is not, however, discounting the possibility that they have the right to any help in

Now say, sir, if the Provincial Government of the Province of Alberta approached M.S.I. and said "Are you prepared to administer such a scheme for us; you are familiar with the patterns, you are doctor-sponsored, you have the medical profession on your Board, you know the ins and outs"; would you support an arrangement whereby the Provincial Government might ask M.S.I. or M.S.A. to become the designated carrier?

Mr. McMillan: If the province went to M.S.A. and M.S.I. and said "We would like to give you the funds to administer prepaid insurance to these people that need it", we would certainly feel that this is a reasonable structure on their part and we would not object to it.

Mr. McMillan: I think: You would support a plan where the Provincial Government of the Province of British Columbia might ask M.S.I. or M.S.A. as a designated carrier?

Mr. McMillan: Working in the field that we have described to you, yes.

Mr. McMillan: Now, sir, the Federal Government, before it could make any federal contribution, would have to set certain regulations such as basic standards of medical care service on a comprehensive basis available to everybody in the province irrespective of age, pre-existing condition, occupational

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3 group - would you accept this or would you feel this  
4 should be somewhat more limited?

5 DR. WATSON: I feel that the Federal  
6 Government, if they were giving the funds to the Provin-  
7 cial Government, may require some basic requirements, but  
8 I can't say how they could say specifically without  
9 restricting the provinces in handling its problem in a  
10 more specific way.

11 In other words, you state it would be  
12 made available to all persons, available - if the  
13 Federal Government or the Provincial Government are not  
14 going to pay in part a great percentage of these it isn't  
15 really any concern of theirs as to whether it is available  
16 to persons they are not going to pay for if it is available to  
people they are going to assist.

17 COMMISSIONER FIRESTONE: As far as the  
18 people they are going to assist, would you have any  
19 objection; it would be available to everybody in that  
20 group irrespective of age, occupation, etc?

21 DR. WATSON: That is right, very  
22 definitely.

23 COMMISSIONER FIRESTONE: The first  
24 point, if the Federal Government were to leave it to  
25 each province how to finance its costs, including the  
26 type of contribution, because some may be expected to  
27 contribute part of the cost; that has been suggested -  
28 what I am suggesting, would you be in favour of a scheme  
29 whereby the Federal Government as part of the terms,  
30 leaves it entirely to the province to arrange for the  
financing on its own?





Group - would you accept that or would you feel this

DR. WILSON: I feel that the Federal

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going to say in part a great percentage of these it isn't

really any concern of theirs as to whether it is available

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COMMISSIONER FLETCHER: As far as the

people they are going to assist, would you have any

objection; it would be available to everybody in that

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DR. WILSON: That is right, very

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whereby the Federal Government as part of the terms,

leaves it entirely to the province to arrange for the

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3 DR. WATSON: Yes, we would be in favour  
4 of that.

5 COMMISSIONER FIRESTONE: If the  
6 Federal Government would either leave it to each  
7 province to decide whether such a program should be  
8 voluntary or compulsory; how would you feel about that?

9 DR. WATSON: I am sorry, I didn't hear  
10 which government.

11 COMMISSIONER FIRESTONE: If the Federal  
12 Government were to say "It is up to each province whether  
13 the program in that province should be voluntary or  
14 compulsory", what would be your views?

15 DR. WATSON: You have come out of the  
16 field...

17 THE CHAIRMAN: Dr. Firestone, I was  
18 going to say, if you expect the doctors to answer that  
19 question, I would expect they would understand it a  
20 little better than I do.

21 How are you going to ask about compulsory  
22 unless you limit it to the group these gentlemen said  
23 they are disposed to at the moment; that is the indigent  
24 group? If you say compulsory within the indigent group  
25 the question may mean something.

26 COMMISSIONER FIRESTONE: Dr. Watson,  
27 there may be a province that wishes to have a compulsory  
28 program.

29 THE CHAIRMAN: Dr. Firestone, I don't  
30 see any purpose in taking an hour to deal with a subject  
that has much narrower limitations. We just have so much  
time. You have carried these gentlemen forward to the



DR. WATSON: Yes, we would be in favour

of that.

Federal Government would either leave it to each province to decide whether such a program should be voluntary or compulsory; now would you feel about that?

DR. WATSON: I am sorry, I didn't hear

which government.

COMMISSIONER FINESTONE: If the Federal Government were to say "it is up to each province whether the program in that province should be voluntary or compulsory", what would be your views?

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THE CHAIRMAN: Dr. Finestone, I was

going to say, if you expect the doctors to answer that question, I would expect they would understand it a little better than I do.

Now are you going to ask about compulsory

unless you limit it to the group these gentlemen said they are disposed to at the moment, that is the indigent group? If you say compulsory within the indigent group the question may mean something.

there may be a province that wishes to have a compulsory

THE CHAIRMAN: Dr. Finestone, I don't see any purpose in taking an hour to deal with a subject that has much narrower limitations. We just have so much time. You have carried these gentlemen forward to the





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3 point they are only talking about medical indigents, 15  
4 or 25%, whatever you want to call it.

5 Now you are moving into a compulsory  
6 scheme that would have 100% of the population.

7 COMMISSIONER FIRESTONE: Mr. Chairman,  
8 if I may explain to Dr. Watson the purpose of my question  
9 in order to be helpful to him.

10 THE CHAIRMAN: The purpose of your  
11 question must also be helpful to the Commission.

12 COMMISSIONER FIRESTONE: There may be  
13 a different interpretation on that point.

14 THE CHAIRMAN: For myself I must make  
15 that judgment.

16 COMMISSIONER FIRESTONE: We all have  
17 to make the best judgment we can, sir.

18 Dr. Watson, you realize in different  
19 provinces there are different points of view. In some  
20 provinces the view may be to hold that a compulsory  
21 scheme is desirable. In some provinces the view may be  
22 to hold that a voluntary scheme is desirable.

23 In developing the federal thought, the  
24 problem the Federal Government faces is to devise a plan  
25 that would meet the requirements of all ten provinces.  
26 If the medical profession of the Province of British  
27 Columbia feels what this province requires is a voluntary  
28 plan with full coverage for medical indigents, I think  
29 you are fully entitled to that view.

30 What I am trying to find out: one must  
take into account the point of view of the other provinces;  
the people in the other provinces may be different.



point they are only talking about medical indigents, is  
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scheme that would have 100% of the population.  
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in order to be helpful to him.  
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COMMISSIONER WILSON: There may be  
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a statement. We all have  
to make the best judgment we can, and  
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take into account the point of view of the other provinces  
the people in the other provinces may be different.



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3 Therefore, the Federal Government, in developing a plan,  
4 may have to develop one that meets the requirements of  
5 the Province of British Columbia and the requirements  
6 of another province that may want to do something else.

7 My question is, have you any objection  
8 to a federal plan which gives this province 100% compul-  
9 sory coverage and one that gives B.C. the more limited  
10 plan because that is what they want? That is simply my  
11 question.

12 DR. WATSON: We have now moved out of  
13 the field of actualities and we are talking about philo-  
14 sophy. I am quite willing to go on with you. You have  
15 said if the Federal Government wished to allow some  
16 provinces to be compulsory and some provinces to be  
17 voluntary in a medical care program, which we are know-  
18 ledgeable about, I would say we would be disturbed if a  
19 province was allowed to have a compulsory system because  
20 it is our feeling that if everybody is covered by one  
21 group, by one overall monetary supply, that rigid controls  
22 enter in, which do not allow medical care to progress at  
23 a normal rate.

24 They must listen to the recipients,  
25 the people in the group, the indigent group, the medical  
26 profession, the public, even the political parties. We  
27 would be disturbed if a compulsory plan went into effect  
28 in, say, Alberta.

29 We are not so short-sighted to think  
30 we are a body apart. Any medical care program that is  
coming in, it is going to have to be transferred from one  
province to the other. We have run into this in the







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3 prepayment field.

4 We are not saying anybody does not  
5 have the right to make up their mind. We would be  
6 disturbed if they made it up to have a compulsory plan.

7 COMMISSIONER FIRESTONE: Some provinces  
8 may have different views to the Province of British  
9 Columbia. You would have no objection to the people of  
10 the provinces making up their minds the way they saw fit?

11 DR. WATSON: We have no objection to  
12 them making up their minds. We would object to the fact  
13 it existed in Canada. We would try to change it.

14 COMMISSIONER FIRESTONE: If I under-  
15 stand your answer to my question, you wouldn't be in  
16 favour of a federal plan which leaves to the discretion  
17 of the province whether they want to introduce a voluntary  
18 plan with limited coverage that you have in mind in  
19 another province, or may wish to have a compulsory plan  
20 covering everybody.

21 The answer to my question would be yes  
22 or no, am I right?

23 DR. BELL-IRVING: No.

24 DR. WATSON: We would object to this,  
25 yes,

26 COMMISSIONER FIRESTONE: I got yes and  
27 no.

28 DR. WATSON: I am sorry, I forgot where  
29 your question was going.

30 COMMISSIONER FIRESTONE: You can simply  
answer yes or no, sir. If the Federal Government developed  
a plan where it would leave it to each province to decide

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COMMISSIONER FRANKS: If I under-

stand you answer to my question, you wouldn't be in  
favor of a federal plan which leaves to the discretion  
of the province whether they want to introduce a voluntary

plan or a compulsory one? I may wish to have a compulsory plan  
covering everything.

The answer to my question would be yes

or no, am I right?

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Your question was going.

COMMISSIONER FRANKS: You can simply

answer yes or no, sir. If the Federal Government developed  
a plan where it would leave it to each province to decide





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3 whether they wished to go ahead with it on a voluntary  
4 or limited basis the way you suggested or a compulsory  
5 and comprehensive basis that some other provinces may  
6 wish, would you be in favour of such a proposal?

7 DR. WATSON: No.

8 COMMISSIONER FIRESTONE: Thank you  
9 very much.

10 DR. McCOY: I would like to add I  
11 object as a doctor and as a taxpayer. I would be against  
12 it.

13 COMMISSIONER McCUTCHEON: You are  
14 opposed to having tax money paid for the benefit of  
15 people who can support themselves?

16 DR. McCOY: Right.

17 COMMISSIONER McCUTCHEON: One question,  
18 Dr. Watson: it is like asking whether you are for sin or  
19 not. You are in favour of a study being undertaken to  
20 determine if drug costs are high. Have you any reason  
21 to believe they are high? What is the standard? Are  
22 they high in relation to what?

23 DR. WATSON: I felt, when I answered  
24 that question, I was a little negligent. I feel a  
25 study certainly should be made to understand the value  
26 of the drugs and to put that value in some relationship  
27 to cost.

28 COMMISSIONER McCUTCHEON: By value,  
29 do you mean therapeutic value?

30 DR. WATSON: The benefit this medication  
gives.

COMMISSIONER McCUTCHEON: The





therapeutic value?

DR. WATSON: Must be measured against its cost. You cannot say any drug is costly if it is the only medication that is going to make a person better, or even well. In my mind a medicine is only high in cost when it costs a great deal more than it has benefit to the patient in other respects.

COMMISSIONER McCUTCHEON: Thank you very much.

THE CHAIRMAN: Thank you, gentlemen.

DR. WATSON: Thank you very much.

THE CHAIRMAN: We will have a short recess.

--- Short Recess





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DR. WALTON: That he measured against

its cost. You cannot say any drug is costly if it is

the only medication that is going to make a person better

or even well. In my mind a medicine is only high in

cost when it costs a great deal more than it has benefit

to the patient in other respects.

COMMISSIONER McCUTCHEN: Thank you

very much

DR. WALTON: Thank you very much.

THE CHAIRMAN: We will have a short

--- short recess



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3 THE CHAIRMAN: Ladies and gentlemen,  
4 if we may come to order we will proceed with the joint  
5 submission of The College of Dental Surgeons of British  
6 Columbia and The British Columbia Dental Association.

7  
8 --- EXHIBIT NO. 151: Joint Submission of The College of  
9 Dental Surgeons of British Columbia  
10 and The British Columbia Dental  
11 Association.

12  
13 JOINT SUBMISSION OF THE COLLEGE OF DENTAL SURGEONS  
14 OF BRITISH COLUMBIA AND THE BRITISH COLUMBIA  
15 DENTAL ASSOCIATION

16  
17 Appearances: Dr. W. Munsie  
18 Dr. G.A. Freeze  
19 Dr. C. Gardner  
20 Dr. A. Swanson  
21 Dr. R. Upton  
22 Dr. J. Lewis  
23 Dr. E. Slakov  
24 Dr. D. Yeo

25 DR. MUNSIE: Mr. Chairman, my name is  
26 Wesley Munsie, and I would like at this time to introduce  
27 my colleagues. On my extreme right, Dr. Frieze, who is  
28 a member of the Brief Committee; Dr. Gardner, who is  
29 President of the Vancouver Dental Society; Dr. Swanson,  
30 who is Chairman of our Brief Committee; and on my  
extreme left, Dr. Yeo, head of the Preventive Dental  
Services, City of Vancouver; Dr. E. Slekov, Chairman of  
the Health Insurance Study Commission of the B.C. Dental  
Association; Dr. J.C. Lewis, President of the British  
Columbia Dental Association and Dr. Upton, who is Executive  
Secretary of both bodies.

THE CHAIRMAN: Thank you.

DR. MUNSIE: Mr. Chairman and members







of the Commission:

SUMMARY

1. The people of British Columbia, in all probability, vary but little from the people of the nine other Canadian provinces in terms of the incidence of dental disease, the availability of dental personnel to treat these diseases, and current methods for preventing such diseases. It is also probable that the people of this province would express views parallel to the rest of their fellow Canadians in terms of their desire for some means by which they might receive adequate and complete dental care regardless of their economic status. The dental profession in British Columbia is indeed aware that a changing socio-economic wave is rippling across this land. It is with this in mind that the dental profession in British Columbia welcomes this opportunity to review its current status and to offer its comments regarding the prospects for the future.

2. Certain facts and statistics are available which are interesting and enlightening and which may serve to unfold before you a true picture of British Columbia dental services, dental personnel and dental teaching facilities. They may also serve to assist in forecasting needs for the future in terms of dentist-population ratio and personnel requirements. Advantage is taken of this opportunity for the dental profession in British Columbia to do some soul-searching, to present for public consumption its evaluation of its own contribution to society and its considered opinion regarding the position of dentists and dentistry in any



SUMMARY

of the Commission:

1. The people of British Columbia, in all probability, vary but little from the people of the nine other Canadian provinces in terms of the incidence of dental disease, the availability of dental personnel to treat these diseases, and current methods for preventing such diseases. It is also probable that the people of this province would express views parallel to the rest of their fellow Canadians in terms of their desire for some means by which they might receive adequate and complete dental care regardless of their economic status. The dental profession in British Columbia is indeed aware that a changing socio-economic wave is rippling across this land. It is with this in mind that the dental profession in British Columbia welcomes this opportunity to review its current status and to offer its comments regarding the prospects for the future.

2. General facts and statistics are available which are interesting and enlightening and which may serve to paint before you a true picture of British Columbia dental services, dental personnel and dental teaching facilities. They may also serve to assist in forecasting needs for the future in terms of dentist-population ratios and personnel requirements. Advantage is taken of this opportunity for the dental profession in British Columbia to do some soul-searching, to present for public consumption its evaluation of its present position and its suggestions for the future regarding the position of dentists and dentistry in any



1  
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3  
4 contemplated comprehensive health scheme. After reviewing  
5 these matters it may then be possible to arrive at  
6 certain conclusions and recommendations. This is the  
7 objective of this Brief.

8 CONCLUSIONS AND RECOMMENDATIONS

9 Dental School Need (p.45-47)

10 3. The dentist-population ratio is  
11 worsening in British Columbia at an alarming rate. It  
12 is already worse than predicted for 1970 by an authorita-  
13 tive investigator who studied this matter for the Univer-  
14 sity of British Columbia in 1956 and again in 1961. It  
15 is particularly poor in the rural areas.

16 4. THEREFORE, it is recommended that  
17 there be established immediately a School of Dentistry  
18 on the campus of the University of British Columbia,  
19 according to the Prospectus authored by Dr. John B.  
20 Macdonald.

21 THE CHAIRMAN: Has not that picture  
22 changed since you wrote this?

23 DR. MUNSIE: It has, indeed, sir. We  
24 are very delighted, and I could enlarge on this. Would  
25 you like me to omit the parts pertaining to the School  
26 of Dentistry?

27 THE CHAIRMAN: Certainly those parts  
28 urging establishment of a school, if its establishment  
29 has been announced. You can leave them in, however.

30 DR. MUNSIE: That is all right, sir.  
Thank you very much for permitting me to make this more  
brief.





concentrated comprehensive health scheme. After reviewing these matters it may then be possible to arrive at certain conclusions and recommendations. This is the objective of this report.

# CONCLUSIONS AND RECOMMENDATIONS

Dental School (1955-1956)

8. The dental-population ratio is worsening in British Columbia at an alarming rate. It is already worse than predicted for 1950 by an authoritative investigator who studied this matter for the University of British Columbia in 1956 and again in 1957. It is particularly poor in the rural areas.

9. THEREFORE, it is recommended that there be established immediately a School of Dentistry on the campus of the University of British Columbia, according to the proposals submitted by Dr. John B. Macdonald.

10. THE CHAIRMAN: Has not that picture changed since you wrote that?

11. DR. WHITE: It has, indeed, and we are very delighted, and I could exchange on this. Would you like us to turn the gears pertaining to the School of Dentistry?

12. THE CHAIRMAN: Certainly those parts urging establishment of a school. If the establishment has been announced, you can leave them in, however.

Thank you very much for permitting me to make this more brief.



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3 Financial Assistance for Dental Students (p.49-51)

4 5. It would appear that the high cost  
5 of dental education is another of the factors operating  
6 today to deter otherwise prospective students from  
7 entering upon a dental career.

8 6. THEREFORE, it is recommended that  
9 the federal government assist the provincial government  
10 to enlarge the bursaries for qualified students interested  
11 in pursuing a course in dentistry to the extent of  
12 enabling them to complete their dental education. Proof  
13 of financial need would have to be established. This  
14 loan could be repayable on an interest-free, contractual  
15 basis following graduation. A modification in the repay-  
16 ment conditions of this loan could be made to encourage  
17 graduates to locate immediately in rural areas where the  
need is greatest.

18 Recruitment of Dental Personnel (p.47-52)

19 7. Recruitment of competent young  
20 people to the dental profession is recognized as a  
21 national problem. The British Columbia Dental Associa-  
22 tion has taken positive steps toward recruiting more  
23 students to the study of dentistry and dental hygiene.  
24 The results of this program over the past year are  
25 reflected by the fact that an 86% increase in pre-dental  
26 enrolment at the University of British Columbia over  
27 last year has been recorded. Unfortunately, however,  
28 University authorities indicate that a significant number  
29 of these potential dentists are lost to the profession  
30 because there is no dental school on this campus.  
Equally important is the need to recruit qualified young



5. It would appear that the high cost of a dental education is another of the factors operating today to deter otherwise prospective students from entering upon a dental career.

6. THEREFORE, it is recommended that the federal government assist the provincial government to enlarge the facilities for qualified students interested in pursuing a course in dentistry to the extent of enabling them to complete their dental education. Proof of financial need would have to be established. This loan could be repayable on an interest-free, contractual basis following graduation. A modification in the repayment conditions of this loan could be made to encourage graduates to locate immediately in rural areas where the need is greatest.

Recommendation of Dental Personnel (Dental)

7. Recruitment of competent young people to the dental profession is recognized as a national problem. The British Columbia Dental Association has taken active steps toward recruiting more students to the study of dentistry and dental hygiene. The results of this program over the last year are reflected by the fact that an 88% increase in pre-dental enrollment at the University of British Columbia over last year has been recorded. Unfortunately, however,

of these potential dentists are lost to the profession because there is no dental school on this campus. Equally important is the need to recruit qualified young





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3 women to the field of dental hygiene. There is a great  
4 paucity of these dental ancillary workers in British  
5 Columbia and their value in the total dental health  
6 service picture is unquestioned.

7 8. THEREFORE, it is recommended that  
8 the dental profession itself lead the way through further  
9 expansion of a well-integrated provincial and federal  
10 recruitment program using all means available, including  
11 high school counselling, motion picture, newspaper  
12 advertisements, etc., to attract the highest qualified  
13 students available into this profession. This, the  
14 dental profession of British Columbia believes, can best  
be done by dentists themselves.

15 Fluoridation (p.20-24)

16 9. Only 3.2% of the population of  
17 British Columbia is at present enjoying the proven bene-  
18 fits of one of the most impressive public health measures  
19 of all time -- the fluoridation of communal water  
20 supplies. Twenty-five communities in this province have  
21 failed to approve this measure in plebiscites, which  
22 require a 60% affirmative vote according to existing  
23 provincial legislation. To hinder the advent of this  
24 proven, preventative measure by weighted legislation is  
most unreasonable and retrogressive.

25 10. THEREFORE, it is recommended that  
26 the issue of fluoridation be removed from the political  
27 field; that strong federal influence be brought to bear  
28 upon the provincial governments to establish legislation  
29 or change existing legislation in order to enable muni-  
30 cipal councils to institute fluoridation of their water





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3 supplies without a public referendum being required;  
4 that the policy laid down by the Ontario Fluoridation  
5 Investigating Committee and tabled in the Ontario Legis-  
6 lature, February 21, 1961, be adopted. Where proof of  
7 financial need exists, municipalities should be given  
8 financial assistance by provincial and federal governments  
9 towards the cost of installing and maintaining fluorida-  
10 tion equipment.

11 Dental Hygienists (p.26-31)

12 under the heading 11. There is a changing philosophy  
13 developing in the dental profession regarding the role  
14 which can be played by the dental hygienist in attempting  
15 to fulfill the need for rendering more good dental  
16 services to more people. This valuable ancillary worker  
17 could conceivably be rendering a wider scope of service  
18 than is presently the case, thereby freeing the dentist  
19 for the more exacting skills and services requiring a  
20 greater degree of scientific knowledge and background.

21 view of the above 12. THEREFORE, it is recommended that  
22 a School of Dental Hygiene be established at the Univer-  
23 sity of British Columbia in order to bring about  
24 increased and extended dental services to the people of  
25 British Columbia. This would greatly facilitate the  
26 dental profession's aim of rendering more service at  
27 less cost to the public.

28 Dental Assistants (p.31-33)

29 13. The dental assistant is virtually  
30 indispensable in contemporary dental practice. She  
increases significantly the productivity of the dentist  
with whom she works. She has become the dentist's





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4 "second pair of hands" and yet there is no formal  
5 training program of the order which the profession feels  
6 is needed, whereby these girls can receive complete  
7 training prior to commencing work with a dentist. This,  
8 again, would increase the productivity of the dentist  
9 since so much time is now spent in training the would-be  
10 assistant by the individual dentist.

11  
12 14. THEREFORE, it is recommended that  
13 a program for training dental assistants be established  
14 under the auspices of the vocational department of the  
15 local school boards. It would be best, of course, if  
16 this could be done under the guidance of a dental school.

17 Dental Technicians and Discipline (p.33-45)

18  
19 15. There exists in British Columbia  
20 a deplorable situation in regard to dental technicians.  
21 Legislation in recent years has been directed towards  
22 offering a solution to this situation but it has been  
23 misguided, and portions of it have been declared "ultra  
24 vires" by the Supreme Court of British Columbia. Some  
25 of this legislation even contravened the Dentistry Act  
26 itself. Some dental technicians in this province are  
27 dealing directly with the public in the realm of diagno-  
28 sing and treatment planning in conjunction with prosthetic  
29 dentistry. This has evolved as a result of a combination  
30 of factors and the public is being exposed to practitioners  
in the health field who have had no formal education in  
the biological sciences, let alone training in a dental  
school. The hazards of such a situation are becoming  
more apparent. It is vital to the health of the people  
of British Columbia that this practice cease, and that



"second pair of hands" and yet there is no formal training program of the order which the profession feels is needed, whereby these girls can receive complete training prior to commencing work with a dentist. This, again, would increase the productivity of the dentist since so much time is now spent in training the workable assistant by the individual dentist.

14. THEREFORE, it is recommended that a program for training dental assistants be established under the auspices of the vocational department of the local school boards. It would be best, of course, if this could be done under the guidance of a dental school.

Dental Technicians and Discipline

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legislation in recent years has been directed towards offering a solution to this situation but it has been misguided, and portions of it have been declared "ultra vires" by the Supreme Court of British Columbia. Some of this legislation even contravened the Dentistry Act itself. Some dental technicians in this province are dealing directly with the public in the realm of diagnosis and treatment planning in conjunction with prosthetic dentistry. This has evolved as a result of a combination of factors and the public is being exposed to practitioners in the health field who have had no formal education in the biological sciences, let alone training in a dental school. The hazards of such a situation are becoming more apparent. It is vital to the health of the people of British Columbia that this practice cease and that





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3  
4 only qualified dentists be responsible for the rendering  
5 of a dental prosthetic service directly to the public.  
6 The Council of the College of Dental Surgeons of British  
7 Columbia has made a proposal to the provincial government  
8 which it feels will offer a sensible and workable solu-  
9 tion to the problem.

10 16. THEREFORE, it is strongly recom-  
11 mended that objective and dispassionate negotiations  
12 between these two bodies continue to the end that an  
13 improved, more efficient and co-operative dental health  
14 team be the result. Also, it is recommended that the  
15 discipline both within and without the profession be  
16 greatly reinforced. The penalties for commission of an  
17 offense against the Dentistry Act of British Columbia  
18 are much too light, and the flagrant violation of portions  
19 of the Act in recent years is a frightening index of the  
20 impunity with which offenders treat the Act. This will  
21 require revision of the present Dentistry Act and such  
22 revision has been recommended.

23 A Prepaid Plan for Dental Care (p.52-55)

24 17. There is need for a prepayment  
25 plan for dental care in British Columbia. The medical  
26 prepayment plans have been eminently successful in this  
27 province and it is felt that a dental counterpart is  
28 needed and wanted by the public. The institution of  
29 such a plan is not a simple problem and experience in  
30 administering it is required before any degree of  
certainty can be achieved as to its ultimate potential.  
However, the British Columbia Dental Association has  
developed such a plan, based on several years of intensive

only qualified dentists be responsible for the rendering of a dental prosthetic service directly to the public. The Council of the College of Dental Surgeons of British Columbia has made a proposal to the provincial government which it feels will offer a sensible and workable solution to the problem.

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mended that objective and dispassionate negotiations between these two bodies continue to the end that an improved, more efficient and co-operative dental health team be the result. Also, it is recommended that the discipline both within and without the profession be greatly reinforced. The penalties for commission of an offense against the Dentistry Act of British Columbia are much too light, and the flagrant violation of portions of the Act in recent years is a frightening index of the impunity with which offenders treat the Act. This will require revision of the present Dentistry Act and such

A Proposed Plan for Dental Care (p. 62-63)

17. There is need for a prepayment plan for dental care in British Columbia. The medical prepayment plans have been eminently successful in this province and it is felt that a dental counterpart is needed and wanted by the public. The institution of such a plan is not a simple problem and experience in administering it is required before any degree of certainty can be achieved as to its ultimate potential. However, the British Columbia Dental Association has developed such a plan, based on several years of intensive



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2  
3 study, which it feels is workable.

4 18. THEREFORE, it is recommended that  
5 the British Columbia Dental Services Association, the  
6 Constitution of which is already residing in Victoria,  
7 be admitted under The Societies Act at once. The  
8 British Columbia Dental Association could then institute  
9 a pilot plan with some interested group and begin to  
10 develop and extend this dental-budgeting principle,  
11 perhaps to all of the province.

A Philosophy Regarding Comprehensive Dental Care (p.55-59)

12 19. It has been clearly stated by the  
13 Chairman of this Royal Commission in his address at the  
14 opening of the preliminary hearing in Ottawa that, "The  
15 view appears to be developing that opportunity for  
16 good health is a right possessed by all and should become  
17 available in one form or another to every citizen in  
18 Canada".

19 20. It is also apparent that the poli-  
20 tical elements of this country are moving, virtually  
21 without exception, towards the principle of a comprehensive  
22 health plan for all Canadians. The dental profession in  
23 British Columbia is dedicated to the idea of maintaining  
24 quality in the dental service it renders. The dental  
25 profession in British Columbia is fully cognizant of the  
26 fact that were a complete comprehensive dental plan  
27 started in this province tomorrow, there simply would  
28 not be nearly enough dentists to render this service.  
29 This statement is based on the fact that all 662 dentists  
30 in this province now are engaged full time in supplying  
dental services to only one-third of the population.



study, which is feasible.

the British Columbia Dental Services Association, the  
Commission of which is already residing in Victoria,

British Columbia Dental Association could then institute  
a pilot plan with some interested group and begin to  
develop and extend this dental-budgging principle,  
perhaps to all of the province.

Philosophy Regarding Comprehensive Dental Care (p. 22-23)

18. It has been clearly stated by the

Chairman of the Royal Commission in his address at the  
opening of the preliminary hearing in Ottawa that, "The  
view is being developed . . . that opportunity for  
good health is a right possessed by all and should become  
available to one from another to every citizen in  
Canada."

19. It is also apparent that the poli-

tical element of this country are in a way, gradually  
without exception, moving the principle of a comprehensive

health plan for all Canadians. The dental profession in  
British Columbia is dedicated to the task of maintaining  
quality in the dental service. The dental

profession in British Columbia is fully cognizant of the  
fact that there is a complete comprehensive dental plan  
emerging in this province tomorrow. The study would  
not be merely a study, but a study to render this service.

20. This statement is based on the fact that all 403 dentists  
in this province now are engaged full time in supplying  
dental services to only one-third of the population.



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4 Although the profession is aware that there is a marginal  
5 income group in this province which cannot truly afford  
6 dental care, the great majority of British Columbians  
7 could budget for their dental care if they so desired.  
8 It would seem to be an extremely unnecessary government  
9 expenditure to provide a so-called "free" dental service  
10 for those people who can already afford their own.  
11 Furthermore, it is important that the emphasis in dental  
12 service should not shift from the children, where it  
13 properly resides in the form of preventive and prophylac-  
14 tic care, to that of an extraction and denture type of  
15 service for adults. This is what happened in Great  
16 Britain and it is a most retrogressive step for the  
17 dental profession and for the public it serves.

18 21. THEREFORE, it is recommended that  
19 any dental care plan instituted in British Columbia at  
20 this time be designed to meet the most urgent needs.  
21 Such a program should begin by providing dental care to  
22 marginal income families not already covered by welfare  
23 services.

24 22. It is further recommended, should  
25 the funds and personnel be available to institute a  
26 fully comprehensive dental care plan at some future  
27 time, that use be made of existing prepayment plan vehicles  
28 in its institution.

29 23. The British Columbia Dental  
30 Association believes that its proposed prepayment plan  
contains a suitable structure which could gradually be  
developed into a comprehensive program to include all  
the people of British Columbia.







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2  
3 Thank you, Mr. Chairman.

4 THE CHAIRMAN: Thank you, Dr. Munsie.  
5 You speak of the prepayment plan. Have you got a pros-  
6 pectus or a format for it?

7 DR. MUNSIE: We have, sir, comprised  
8 a skeleton of a plan which has been registered with the --  
9 or, rather, introduced to the Superintendent of Insurances  
10 in Victoria. It has been forwarded as an exhibit, I  
11 believe, to this hearing, and we are optimistic that  
12 it will be returned to us soon and in almost unaltered  
13 form. At that time, we hope to gain some experience in  
14 this regard.

15 THE CHAIRMAN: Just what are its main  
16 elements?

17 DR. MUNSIE: I think probably, sir,  
18 I should refer this question to the person who has worked  
19 on this the most, Dr. Slakov.

20 DR. SLAKOV: Mr. Chairman, the main  
21 elements of a proposed prepayment dental plan for British  
22 Columbia would be that it would be primarily a non-profit  
23 organization. It would be controlled and administered  
24 by the dental profession with provision for lay directors.  
25 That it should be given its pilot project serving a  
26 group necessarily and we, in our judgment think that  
27 a group of children up to the age of 15 would provide  
28 the best necessary experience and statistical study to  
29 enable us to better expand the service, then, to other  
30 groups and age levels.

--- EXHIBIT NO. 151A: The Societies Act, British Columbia  
Dental Services Association.



You speak of the payment plan. Have you got a prospectus or a form for it?

DR. WATKINS: We have, sir, composed a sketch of a plan which has been registered with the or, rather, introduced to the Superintendent of Insurance in Victoria. It has been forwarded as an exhibit. I believe, to this hearing, and we are optimistic that it will be returned to us soon and in almost a altered form. At that time, we hope to gain some experience in this regard.

THE CHAIRMAN: Just what are the main elements?

DR. WATKINS: I think, probably, sir, I should refer this question to the person who has worked on this the most, Dr. Slaton. Dr. Slaton: Mr. Chairman, the main elements of a proposed management plan for British Columbia would be that it would be primarily a non-profit organization. It would be controlled and administered

that it should be given the right to collect savings group necessarily and, in our judgment, that a group of children up to the age of 15 would provide the best necessary experience and statistical study to enable us to better expand the service, then, to other



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4 THE CHAIRMAN: Talking of bursaries  
5 to assist in dental education, and you suggest, on page  
6 2, modification and repayment conditions could be made  
7 to encourage doctors to locate immediately in rural  
8 areas where the need is greatest.

9 Have you had any success with that  
10 type of condition for bursary?

11 DR. MUNSIE: As at this time, we have  
12 not had any experience with this type of bursary. It  
13 is our hope that with a bursary requiring repayment  
14 that consideration might be given to those who would  
15 settle in an area which might be declared as urgent.

16 If he did, that he be given considera-  
17 tion regarding repayment of his loan.

18 THE CHAIRMAN: Repayment might be  
19 waived completely?

20 DR. MUNSIE: Repayment might be waived  
21 completely, sir, that is right.

22 THE CHAIRMAN: Have you had any  
23 experience -- I mean, have you sought experience how  
24 this works elsewhere?

25 DR. MUNSIE: We have some experience  
26 in Saskatchewan, sir, where the plan is slightly different  
27 in that it is just a matter of if they do not practise  
28 in the province, as we understand it, they have to pay  
29 the whole loan back. If they stay in Saskatchewan as a  
30 whole part of the loan is waived.

31 THE CHAIRMAN: For a period of one or  
32 two years, depending on the length of assistance the  
33 student has had?





to assist in general supervision, and you suggest, on page  
1, modification and repayment conditions could be made  
to encourage doctors to locate themselves in rural  
areas where the need is greatest.  
Have you had any success with that

type of condition on repayment?  
MR. MURPHY: As at this time, we have  
not had any experience with this type of program. It  
is our hope that with a program requiring repayment  
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4 DR. MUNSIE: That is right, sir. The  
5 loans in that regard, I believe, have been fairly  
6 limited, Mr. Chairman, insofar as the amounts were  
7 concerned.

8 THE CHAIRMAN: Now, in this matter of  
9 fluoridation, there have been a number of votes, have  
10 there not, on this fluoridation question in various  
11 municipal areas in British Columbia?

12 DR. MUNSIE: That is correct, sir.

13 THE CHAIRMAN: With what result?

14 DR. MUNSIE: Not too favourable. The  
15 actual statistical result I would ask Dr. Yeo to give  
16 to you, sir.

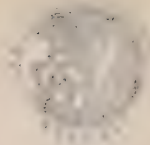
17 DR. YEO: To this date, there have  
18 been 40 communities voting on the issue of fluoridation.  
19 Nine have passed successfully, to the point where the  
20 measure has been instituted, and the other 31 communities,  
21 it has either been defeated or was passed but other  
22 circumstances have prevented them from instituting the  
23 measure.

24 THE CHAIRMAN: How many in this last  
25 category?

26 DR. YEO: Four, sir, and these are in  
27 the Greater Vancouver area where 14 separate municipalities  
28 are supplied by water from one source, and before fluorida-  
29 tion could be instituted they would have to have affirma-  
30 tive votes of all 14 municipalities.

THE CHAIRMAN: In any event, in the  
municipality which supplies the water?

DR. MUNSIE: Yes.



DR. WOOD: That is right, sir. The loans in that regard, I believe, have been fairly limited, Mr. Chairman, insofar as the amounts were

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3 THE CHAIRMAN: What reason, if any,  
4 do you ascribe to the fact that 27 have not voted in  
5 favour of it?

6 DR. MUNSIE: Well, speaking for the  
7 province as a whole, I think probably one of the main  
8 reasons is in the field of education. For our part,  
9 we have done our best. We just haven't seemed to get  
10 across to the public the benefits which they can gather  
11 from the institution of fluoridation. That is, the  
12 benefits concerning their dental health. We just have  
13 not been able to seem to get this across to them.

14 At the same time, of course, there  
15 has been education from the reverse side. There have  
16 been groups who have had anti-fluoridation campaigns in  
17 areas where the vote has been taken, and they have had  
18 greater success than we have had with their education  
19 programs.

20 They have told the people fluoridation  
21 will have serious health hazards, and that they will  
22 suffer illnesses from the institution of fluoridation,  
23 even though it is recommended by the leading health  
24 authorities of the world.

25 COMMISSIONER BALTZAN: Would you call  
26 that reverse thing which you refer to education or propa-  
27 ganda?

28 DR. MUNSIE: We would call it propaganda,  
29 but it is still in the field of education. They have got  
30 their points across, and it is a fear and emotional  
campaign more than an educational campaign.

COMMISSIONER BALTZAN: Have they done



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COMMISSIONER BALTZAN: Have they done



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3 any control experiments to prove their point?

4 DR. MUNSIE: They have not, no.

5 THE CHAIRMAN: Your principle recommen-  
6 dation here appears to be on page 3, going over to page  
7 4, that strong federal influence be brought to bear upon  
8 the Provincial Government to establish legislation or  
9 change existing legislation in order to enable a municipi-  
10 pal council to institute fluoridation of their water  
11 supply without a public referendum being required.  
12 Have you put that forward seriously that the Federal  
13 Government should enter into the field of educating  
14 provincial governments?

15 DR. YEO: We feel that dental disease  
16 is a national problem and needs a national answer, and  
17 this recommendation stems from the Royal Commission on  
18 Fluoridation in Ontario, where they recommended that  
19 municipalities be given the authority to institute  
20 fluoridation without a vote, and then if a petition was  
21 brought forward bearing 10% of the voters' signatures,  
22 a plebiscite would be called on demand.

23 THE CHAIRMAN: That is a purely provin-  
24 cial investigation in Ontario?

25 DR. MUNSIE: Yes, sir.

26 COMMISSIONER STRACHAN: Pardon me. I  
27 question whether the Royal Commission recommended there  
28 be a plebiscite at all. It was the Government that  
29 added that. I do not think the Commission recommended  
30 that a plebiscite should be necessary. It left it to  
the municipal governments.

DR. MUNSIE: That is right.



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4 your answer implied that that was part of the Commission  
5 report.

6 DR. MUNSIE: I am sorry if I gave that  
7 impression. I was summing up what is presently standing  
8 in Ontario.

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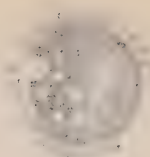
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We can only present the scientific facts that have been founded by dental research and the propagandists can say anything they like about fluoridation and they don't have to prove it.

THE CHAIRMAN: In the matter of your recommendation of a School of Dental Hygiene, where is the closest school here?

DR. MUNSEY: That would be the University of Washington and the nearest Canadian school is the University of Alberta.

THE CHAIRMAN: Have you access to that school? Do pupils from British Columbia go to that school in Edmonton?

DR. MUNSEY: Unfortunately the University of Alberta School of Dental Hygiene just opened this year. There have been graduates from Washington in very limited numbers. The main reason we feel, apart from the fact there is no school here, has been there is a lack of knowledge among suitable candidates and we have, through the setting up of bursaries and information to high school counsellors and through the press, attempted to alleviate that problem.

THE CHAIRMAN: How are your social aid people handled insofar as dentistry is concerned in British Columbia now?

DR. MUNSEY: There is actually three plans and possibly the Executive Secretary may reply to that.

DR. UPTON: Plans in social aid in dentistry in this province are very complicated. Roughly



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5 age and 13 years of age and over although there are  
6 exceptions to these which even the Deputy Minister  
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7 Briefly speaking, under 13, the group  
8 are treated on a fee-for-time basis. The dentists do  
9 the work and they bill the Government at the rate of  
\$10 an hour.

10  
11 THE CHAIRMAN: That is the Department  
of Health or the Department of Social Welfare?

12 DR. UPTON: The Department of Welfare  
13 administers up to the point of paying - is done in the  
14 offices of the Dental Association.

15 THE CHAIRMAN: Where does the Associa-  
16 tion get its funds? From the Department of Welfare?

17 DR. UPTON: The Association, the  
18 members of the Association voluntarily take from each  
19 fee 5% in order to handle the administration costs.

20 THE CHAIRMAN: Are you paid on your  
regular tariff rates on this fee every time?

21 DR. UPTON: No, \$10 an hour does not  
22 work out to the regular tariff, the regular fee-for-  
23 services rates, by any means.

24 THE CHAIRMAN: Is it satisfactory? Is  
25 it reasonably satisfactory?

26 DR. UPTON: No, not at the present  
27 moment. We have made application to the Provincial  
28 Government on an interim basis to have this fee-for-  
29 service increased to \$12 an hour. They are considering  
30 this.



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5 the two schemes combined but I will tell you about the  
6 other scheme now which is on a fee-for-service basis done  
7 on a different basis, different authorization form.

8 THE CHAIRMAN: 13 and over to what age?  
9 Oh, 13 and over;

10 DR. UPTON: Yes, and it chiefly  
11 includes denture patients but all others as well but it  
12 is on a fee-for-service basis, on a fee schedule that we  
13 have previously agreed upon with the Department of  
14 Welfare.

15 THE CHAIRMAN: Is that a regular  
16 schedule of fees?

17 DR. UPTON: No, it is considerably  
18 below.

19 THE CHAIRMAN: What percentage?

20 DR. UPTON: It is rather difficult to  
21 say but I would think across the board it would be about  
22 65% or 70% of the regular fee.

23 THE CHAIRMAN: The dental profession  
24 subsidizes the difference?

25 DR. UPTON: Exactly, yes. There is  
26 this difference too in that the dental profession does  
27 not administer this plan, it is administered by the  
28 Medical Service Director of the Department of Social  
29 Welfare. We work very smoothly with the Medical Service  
30 Division of the Department of Social Welfare and they,  
with us, have recommended to the Minister that these  
two schemes be combined into a fee-for-service plan  
which would encompass all age groups; encompass all the



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4 We would administer up to the point  
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6 now administer the fee-for-time basis. It is very,  
7 very complicated and it is just as complicated to not  
8 only the dentists working on it but to the people both  
9 in government and in our Association who have to administer  
10 it.

11 THE CHAIRMAN: Now then, you recommend  
12 a prepaid plan?

13 DR. MUNSEY: That is correct.

14 THE CHAIRMAN: Those who can pay for  
15 themselves should continue to do so and those who cannot  
16 should have assistance?

17 DR. MUNSEY: Basically, it is our  
18 principle.

19 THE CHAIRMAN: Does your plan contem-  
20 plate doing that on the same basis as you are now looking  
21 after the social welfare cases of over 13?

22 DR. MUNSEY: Not at all on the same  
23 basis as far as fee-for-service is concerned. As far  
24 as administration on such a plan would be an operation  
25 and method of contribution to it would be quite different.

26 THE CHAIRMAN: What contribution would  
27 there be to the plan?

28 DR. MUNSEY: The contribution by the  
29 recipients and/or any other group which may want to  
30 assist them, such as employers.

THE CHAIRMAN: Your prepaid plan would  
include those who are able to pay premiums and may want to?

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DR. MUNSIE: That is right, sir.

THE CHAIRMAN: How would the premiums for the indigents be paid?

DR. MUNSIE: The premium for the indigent, the source of funds, I presume would come from some place, it is now from government agencies. We are now providing monthly schemes that are now operating. It might well be that the members of a prepaid plan could take care of this under a slightly different basis with the source of funds coming from the Government for these indigents.

THE CHAIRMAN: Have you suggested an annual fee, an annual premium charge?

DR. MUNSIE: We have not suggested anything from anybody yet.

THE CHAIRMAN: If you are going to set up a plan of prepayment and you are going to ask somebody to join it, the first thing they will ask is "How much is it going to cost?"

DR. MUNSIE: That is right.

THE CHAIRMAN: What do you suggest is the annual cost?

DR. MUNSIE: I would turn this over to Dr. Slekov, who has worked on this.

DR. SIAKOV: I think the profession is envisaging a program of this sort to start out with a pilot program, therefore, we cannot go by any statistical averages for the whole province. We have, in the past, been approached by several groups who seemed interested in participating in a program of this type



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DR. MUSEL: We have not suggested

anything from anybody yet.

THE CHAIRMAN: If you are going to set up a plan of prepayment and you are going to ask somebody to join it, the first thing they will ask is "how much is it going to cost?"

DR. MUSEL: That is right.

THE CHAIRMAN: What do you suggest is

the annual cost?

DR. MUSEL: I would like to turn this over to

Dr. Sleskov, who has worked on this.

DR. SLESKOV: I think the profession

is envisaging a program of this sort to start out with a pilot program, therefore, we cannot go by any statistical averages for the whole province. We have, in the past, been approached by several groups who seemed interested in participating in a program of this type



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3 and I think probably the largest step of ascertaining  
4 that a particular group could be adequately covered by  
5 this, the personnel available, and we could reach an  
6 agreement as to the type of coverage and cost and so on.

7 The next step would be an actuarial  
8 study.

9 THE CHAIRMAN: You are suggesting a  
10 fee of about \$40 a year?

11 DR. SLAKOV: That is a very wide  
12 approximation. This Committee has realized your great  
13 interest in costs and by the terms of reference given us  
14 you have asked us to, as closely as we can, provide you  
15 with approximations of costs. This is the initial program,  
16 the figure of \$70 and \$40 subsequently up to the age of  
17 15 was developed, using the experience of other programs  
18 along this line.

19 Actually, this figure has been modified  
20 by the conditioned thinking in our own area in the time  
21 interval that has passed.

22 THE CHAIRMAN: Have you a different  
23 figure to submit now?

24 DR. SLAKOV: No sir, this is a figure  
25 that is approximate at this time. It would vary with  
26 the different dental care and dental attention and so on  
27 with the particular group we are going to deal with.

28 COMMISSIONER McCUTCHEON: Is it \$70  
29 per individual or is it \$70 ---

30 DR. SLAKOV: Per individual child.

THE CHAIRMAN: How many children are  
there in British Columbia under 15?

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the different dental care and dental attention and so on  
with the particular group we are going to deal with.  
COMMISSIONER NEULOW: Is it 10?

per individual or is it 20 ---

DR. SLAKOV: Per individual child.

THE CHAIRMAN: How many children are

there in British Columbia under 18?





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4 DR. SLAKOV: I am not sure I have that  
5 specific figure. One reason is that we never have as a  
6 profession contemplated, certainly at this time, covering  
7 any large proportion of the children or adults in this  
8 province for the simple reason that we have not the  
9 personnel.

10 Another important reason is that we  
11 need experience; we must keep in mind there is no such  
12 program existing today in Canada that has, to our know-  
13 ledge, been submitted to a provincial government with  
14 a proposal of this sort. We need experience in admini-  
15 stration capacity of such a program and we need statistics  
16 to find out whether what we believe to be true is actually  
17 true in practice.

18 COMMISSIONER STRACHAN: I have several  
19 questions before me but I want to peruse them very  
20 carefully to see that they do not conflict with those  
21 that have already been asked.

22 First, may I observe how happy we all  
23 were to hear the announcement of your new President of  
24 the University of British Columbia, he being a graduate  
25 of one of our Canadian dental schools. With that announce-  
26 ment I am sure that Canadian dentistry was encouraged  
27 because he, fortunately, was the man who had recommended  
28 the establishment of a dental school in British Columbia  
29 and so, after many years of effort by Canadian dentistry  
30 and by the Canadian Dental Association, it is most grati-  
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First, may I observe how happy we all were to hear the announcement of your new President of the University of British Columbia, he being a graduate of one of our Canadian dental schools. With that announcement I am sure that Canadian dentistry was encouraged because he, fortunately, was the man who had recommended the establishment of a dental school in British Columbia and so, after many years of effort by Canadian dentistry and by the Canadian Dental Association, it is most gratifying to know that the establishment of a dental school in British Columbia has finally been announced.

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3 this brief was written long before that announcement and,  
4 consequently, it changes the context very considerably.  
5 However, there are a few questions which I would like to  
6 ask about with reference to the school.

7 The first one would be, do you hope,  
8 or is there any assurance, that a School of Dental  
9 Hygiene will be established?

10 DR. MUNSIE: There is no assurance  
11 but we do hope and have every reason to be optimistic  
12 and it is our belief that the Premier, when he made his  
13 broad announcement, is following the recommendations of  
14 Dr. Macdonald, in which he states, without a School of  
15 Dental Hygiene, the needs of dentistry in this province  
16 cannot possibly be met. It is our feeling that certainly  
17 this will become a part of the Faculty of Dentistry; it  
18 is certainly our hope.

19 COMMISSIONER STRACHAN: Then, in view  
20 of the establishment of a school are the mechanics  
21 already set up for dental students to obtain bursaries?

22 DR. MUNSIE: No, they are not that we  
23 are aware of. It is certainly our hope that bursaries  
24 will be made available which will make it possible for  
25 any student with the qualifications and the desire, who  
26 wishes to embark on a course in dentistry, we hope that  
27 no one in this province will be barred from this because  
28 of lack of funds.

29 We certainly hope that bursaries are  
30 available for this purpose and it is the strong recommenda-  
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4 COMMISSIONER STRACHAN: In your brief,  
5 on page 50, you refer to loans which may be obtained from  
6 the University of British Columbia. Is it your under-  
7 standing that these loans will be readily available to  
8 dental students?

9 DR. MUNSIE: Yes, it is, to the extent  
10 that they are available. Now, I think it is our under-  
11 standing there are not sufficient funds to give the  
12 support which is at times required for people who are  
13 anxious to proceed on a professional course with its  
14 expenses, to complete it. We hope this situation will  
15 be rectified so, as I have said earlier, no one will be  
16 denied a dental education for lack of funds.

17 COMMISSIONER STRACHAN: At the present  
18 time these loans referred to are not too readily  
19 available?

20 DR. MUNSIE: They are available but  
21 dental education is expensive and experience has shown  
22 there are many students who wish to go into dentistry  
23 but are limited by the financial obstacles before them.

24 COMMISSIONER STRACHAN: Speaking of  
25 students who wish to go into dentistry, and certainly the  
26 profession and the University of British Columbia are to  
27 be commended for their activities in recruitment. As to  
28 the activities and what difficulties are run into in  
29 trying to convince students of high standing to enter  
30 industry, what are the difficulties? Possibly you  
could explain it?

DR. MUNSIE: Generally, there have been  
numerous studies done of this and one was done a number



on page 50, you refer to loans which may be obtained from the University of British Columbia. Is it your understanding that these loans will be readily available to dental students?

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2  
3 of years ago by the American College of Dentists and it  
4 refers to the Nicholson Report and they studied this  
5 matter very carefully. I think the view of prospective  
6 students is that the profession offers an area of very  
7 arduous work.

8 The second reason was that they felt  
9 they could get a greater remuneration in other fields  
10 for the same length of time of education. All these  
11 things, of course, must be very apparent.

12 Locally speaking, we have found there  
13 has not been enough attention to prospective students  
14 at the high school level and we have, in British Columbia,  
15 instituted a series of newspaper advertisements trying to  
16 encourage people to enter the profession; we have  
17 established bursaries through the colleges and the  
18 British Columbia Dental Association and we have carried  
19 on a vigorous campaign through high school counsellors  
20 who are in contact with these students daily, to encourage  
21 them to suggest dentistry as a career for their students.

22 We have also organized a pre-dentistry  
23 society on the campus of the University of British Colum-  
24 bia and it would appear they will be a much greater  
25 source of good dental students than there has been in  
26 the past.

27 /dpw COMMISSIONER STRACHAN: Because the  
28 school is now here and they will not have to leave the  
29 province.

30 DR. MUNSIE: I don't think there is  
any question there this will be a great inducement for  
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DR. WHEELER: I don't think there is

any question there that will be a great incentive for

the citizens, the young citizens of this province, to



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3 enter into a career of dentistry.

4 COMMISSIONER STRACHAN: Has any sugges-  
5 tion been made as to the size of the classes that will  
6 be taken?

7 DR. MUNSIE: Yes sir, Dr. Macdonald,  
8 in his recommendation, has the size of classes, the  
9 ultimate size; 40 students. It is his hope they  
10 will take their first 15 students in the year of 1963.

11 COMMISSIONER STRACHAN: Most encouraging.  
12 Coming back to the subject of fluoridation; in these  
13 plebiscites which have been taken, have you any idea of  
14 the financial group that may have been predominantly  
15 against it? I will put the question another way, not  
16 wishing to lead you to an answer: are the people who  
17 have voted against fluoridation - do they represent the  
18 families most in need of fluoridation? In other words,  
19 are these a group of people who live on suspicions  
20 created by the anti-fluoridationist group?

21 DR. MUNSIE: I would say that is true,  
22 sir. The basic anti-fluoridation campaign is based on  
23 fear which institutes from the substitution in the water  
24 supply of deficient fluoride content. I think we all  
25 recognize the fact that when one starts mentioning the  
26 possibility of getting cancer or other dreaded diseases,  
27 it isn't hard to sway some people who don't have the  
28 facts at hand that it is not a particularly good thing  
29 for them.

30 With respect to the funds which have  
been available I have no knowledge on this. If anybody  
has I would ask them to comment on that.



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be taken.

DR. MUMFORD: Yes sir, Dr. Macdonald,

in his recommendation, has the size of classes, the

ultimate size, 50 students.

will take that first 15 students in the year of 1954.

COMMISSIONER STANLEY: That encouraging.

Coming back to the subject of fluoridation, in these

publicities which have been taken, have you any idea of

the financial group that may have been predominantly

wishing to lead you to an answer and the people who

have voted against fluoridation - do they represent the

financial part in need of fluoridation in other words,

are there a group of people who have an economic

interest in the anti-fluoridation group?

DR. MUMFORD: I would say that is true,

and the anti-fluoridation campaign is based on

fact which originates from the substitution in the water

supply of different fluoride content. I think we all

recognize the fact that when one starts questioning the

possibility of getting cancer or other disease

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4 DR. YEO: The only specific instance  
5 I could recall is the fact, in the City of Vancouver,  
6 the day after the vote was taken, one newspaper published  
7 a map of the city which was divided into polling districts  
8 and the polling districts which voted Yes for fluorida-  
9 tion were in light and the polling districts who voted  
10 against were dark, and the city was divided almost in  
11 half.

12 The western section of the city voted  
13 yes and the eastern section of the city voted no. From  
14 a dental health survey we have carried on in the city,  
15 the eastern section, where the majority voted no, was  
16 the area where fluoridation is mostly needed. That is  
17 true.

18 COMMISSIONER STRACHAN: The low income  
19 group?

20 DR. YEO: Yes sir.

21 COMMISSIONER STRACHAN: You speak of  
22 financial assistance for municipalities wishing to  
23 fluoridate their communal water supply. How would you  
24 get the funds?

25 DR. MUNSIE: We believe if a community  
26 wished to fluoridate their water supply and found they  
27 weren't in a financial position to do so, if such should  
28 be the case, this should not be a barrier to the institu-  
29 tion of fluoridation in that area.

30 COMMISSIONER STRACHAN: Under federal  
legislation adopted recently, in support of technical  
training, are new facilities developing in British  
Columbia?



DR. YEO: The only specific instance

I could recall is the fact, in the City of Vancouver, the day after the vote was taken, one newspaper published a map of the city which was divided into polling districts and the polling districts which voted Yes for fluoridation were in light and the polling districts who voted against were dark, and the city was divided almost in half.

The western section of the city voted yes and the eastern section of the city voted no. From a dental health survey we have carried on in the city, the eastern section, where the majority voted no, was the area where fluoridation is mostly needed. That is

COMMISSIONER STRANDBERG: The law requires

DR. YEO: Yes sir.

COMMISSIONER STRANDBERG: You speak of

financial assistance for municipalities wishing to fluoridate their communal water supply. How would you get the funds?

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4 DR. MUNSIE: Yes sir, we are very  
5 happy to say, very recently again, we have been in  
6 consultation with the vocational school board here and  
7 it would appear that there will be set up, almost  
8 immediately, a course for the training of dental assis-

9 tants and dental technicians in this regard.  
10 They have been most helpful in assisting  
11 us along these lines. It seems almost coincidental with  
12 the arrival of this Commission that many of the things  
13 we felt were lacking in this brief are coming to pass.

14 We certainly hope you gentlemen come  
15 around here again. We are hopeful that area also will  
16 be taken care of in the future.

17 COMMISSIONER STRACHAN: That is too  
18 most encouraging.

19 Coming to another situation, you go to  
20 considerable length in your brief, about ten pages, to  
21 relate the situation whereby unqualified individuals  
22 practise directly for the public. What, in your opinion,  
23 is the main reason for this development?

24 DR. MUNSIE: Well, sir, I think it is  
25 a case - it is a certain amount of history. I think one  
26 of the main reasons probably is that there has been, up  
27 to 1958, no control of dental technology with respect to  
28 legislature.

29 I think that has quite a bearing on it.  
30 I think during the war and subsequent to the war there  
was a very critical shortage of dental personnel in this  
province, in this city; I think that has been a factor  
in developing it. I think probably those two areas are





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3 probably the most important reasons for this situation.

4 COMMISSIONER STRACHAN: Would you care  
5 to tell this Commission what you recognize as the proper  
6 relationship between the dentist and the technician?

7 DR. MUNSIE: Our greatest concern, sir,  
8 is that the prime factor in treating any area of health  
9 service is in the proper diagnosis and treatment planning  
10 of what has to be done with the individual. We don't  
11 feel, nor has any Commission which has studied this  
12 subject felt, that anybody but a properly trained, quali-  
13 fied dentist is able to provide the services.  
14 We feel the public is not being subjected  
15 to the service to which they are entitled. That is our  
16 greatest concern.

17 COMMISSIONER STRACHAN: Are these indi-  
18 viduals remaining within the realm that permissive legis-  
19 lation was passed but has been declared ultra vires?

20 DR. MUNSIE: No sir, the evidence is  
21 on hand that even those who were licensed under Division  
22 10, which has since been declared ultra vires, are doing  
23 work which goes beyond the work which they were legally  
24 entitled to do for the period of time they were.

25 Their areas of activity have not been  
26 confined to their regulations. I have an exhibit here  
27 which I would be happy to leave with the Commission to  
28 substantiate this.

29 COMMISSIONER STRACHAN: We would be very  
30 happy to have it. Common to other provinces, British  
Columbia has a problem in supplying rural dental services.  
Has the profession made any effort to meet this demand







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3 and, in your opinion, what is the real answer to it?

4 DR. MUNSIE: Yes sir, we have been  
5 very concerned with this matter for a good many years.  
6 We feel we have made some progress in this regard through  
7 advertisements in dental journals and solicitations at  
8 dental schools and showing pictures and slides of these  
9 areas that need dentists.

10 We have been fairly successful with  
11 the manpower at our disposal of getting dentists into  
12 the rural areas; not to the degree that would meet the  
13 demand. I think ultimately the only thing which will  
14 provide these necessary services is basically the law  
15 of supply and demand.

16 It is our hope that the institution  
17 of the Faculty of Dentistry, with the institution of the  
18 recommendations for the training of service personnel to  
19 be provided by proper dental hygienists, that this thing  
20 will come.

21 They have now the hope of seeing this  
22 need filled. Up to a little while ago it seemed hopeless.  
23 We now have reason for encouragement.

24 COMMISSIONER STRACHAN: I should like  
25 to observe we are getting considerable encouragement  
26 in the dental field in British Columbia. If unlimited  
27 financial support is made available, what order of  
28 priority would you consider for us to establish improved  
29 dental health in British Columbia?

30 DR. MUNSIE: I hardly thought of  
unlimited funds being available, sir. I think I would  
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of the Faculty of Dentistry, with the institution of the

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4 most urgent area of need is in the development of  
5 preventive measures, to prevent dental disease and  
6 research and preventive treatment service.

7 I think those would have to stand in  
8 our view, at the top of the list. I would think  
9 secondly these people who are in a marginal income  
10 bracket, who are not able to, but who would want to  
11 avail themselves of dental services, I think they need  
12 assistance.

13 I would say those two areas would be  
14 one and two in any priority.

15 COMMISSIONER STRACHAN: Then, coming  
16 back to the question that Dr. Upton dealt with regarding  
17 these groups under and over 13, that includes everybody;  
18 are these two schemes applicable only to social service  
19 personnel?

20 DR. MUNSIE: I believe the two schemes  
21 that Dr. Upton referred to are.

22 COMMISSIONER STRACHAN: What number or  
23 percentage would they represent?

24 DR. UPTON: 74,000.

25 COMMISSIONER STRACHAN: Then, what  
26 is the situation of school dental service in British  
27 Columbia in general and Vancouver in particular?

28 DR. MUNSIE: We are very happy to say,  
29 sir, there has been excellent co-operation between the  
30 dental profession and the various levels of government  
service in providing what we believe to be a very progres-  
sive school dental service.

Dr. Yeo has been intimately associated





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4 with it and I would like to have him speak on this.

5 DR. YEO: Specifically, in the Greater  
6 Vancouver area, we have a preventive dental program  
7 which is aimed at the younger-aged child population.  
8 We hope to achieve blanket coverage of the youngest age  
9 group we can cover with dental service.

10 Our program is limited to Grade I, to  
11 Grade I children, and as many pre-school children as  
12 we have dental time to handle. The program is aimed  
13 at getting all children of this age under dental care  
14 with a family dentist; to bring the parents in and  
15 educate the parents as to what they can do at home to  
16 prevent dental disease.

17 So many parents seem to think dental  
18 disease is inevitable and they sit back and let it  
19 happen. I feel one of the important aims in the educa-  
20 tional field is teaching the parents. Where we can  
21 bring in the parents and the children into the dental  
22 clinic or office to show them there is a great deal they  
23 can do at home to prevent dental disease.

24 Through the family dentist in Vancouver  
25 and the 22 dental clinics we have established ourselves,  
26 we try to provide dental treatment for all these children.

27 COMMISSIONER STRACHAN: What are the  
28 points stressed to the parents, Doctor; the main  
29 points stressed?

30 DR. YEO: The main points stressed in  
the preventive side at home are immediate brushing after  
meals, restriction of carbohydrates, especially between  
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3 stannous fluoride, which is a known preventive measure,  
4 and, of course, we hope we will get fluoridation to  
5 assist us in our preventive program.

6 The third point between home and the  
7 dentist is yearly and regular dental treatment beginning  
8 at the age of 3 for every child.

9 COMMISSIONER STRACHAN: You spoke of  
10 22 clinics. What personnel have you got to handle  
11 these clinics?

12 DR. YEO: We have 21 full-time dentists  
13 and one half-time dentist in the Greater Vancouver area.

14 COMMISSIONER STRACHAN: Any hygienists?

15 DR. YEO: We have no hygienists, no  
16 sir.

17 COMMISSIONER STRACHAN: Then, I take it,  
18 that the students are taken in classes to attend school  
19 clinics. Are they also permitted to attend private  
20 dentists, family dentists, in school hours?

21 DR. YEO: Yes sir.

22 COMMISSIONER STRACHAN: No difficulty  
23 you have experienced?

24 DR. YEO: No.

25 COMMISSIONER STRACHAN: I am happy to  
26 learn that because apparently the situation is entirely  
27 opposite in the City of Victoria.

28 DR. YEO: We have had some complaints  
29 from some individual schools where a child may be kept  
30 out of school for an entire day for a 30-minute dental  
appointment, but overall I would say no complaints about  
dental appointments during school hours either in our



standards fluoride, which is a known preventive measure,  
and, of course, we hope we will get fluoridation to  
assist us in our preventive program.

The third point between home and the  
dentist is yearly and regular dental treatment beginning  
at the age of 3 for every child.

COMMISSIONER STANLEY: You spoke of

12 clinics. What personnel have you got to handle  
these clinics?

DR. YLW: We have 11 full-time dentists  
and one half-time dentist in the Greater Vancouver area.

MR. EOB: We have no hygienists, no

etc.

COMMISSIONER STANLEY: Then, I take it,

that the students are taken in classes to attend school  
clinics. Are they also permitted to attend private  
dentists, family dentists, in school hours?

COMMISSIONER STANLEY: In a community

you have experience?

DR. YLW: Yes.

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opposite in the City of Victoria.

DR. YLW: We have had some complaints

from some individual schools where a child may be kept  
out of school for an entire day for a 30-minute dental  
appointment, but overall I would say no complaints about  
general appointments during school hours except in our





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3 dental clinics or private dental offices.

4 COMMISSIONER STRACHAN: Is it recognized  
5 by your truant officer?

6 DR. YEO: Yes.

7 COMMISSIONER STRACHAN: No difficulty  
8 at all. One last question, I think. In the suggested  
9 prepayment plan you have under consideration, will this  
10 include orthodontic preventive, orthodontic appliance  
11 and exodontia?

12 DR. MUNSIE: I would say in orthodontic  
13 appliance, I don't think it would be orthodontic service,  
14 per se, for two reasons:

15 A. Cost, and

16 B. Lack of orthodontic personnel to  
17 render such.

18 With respect to exodontia I would say  
19 it definitely would be included.

20 COMMISSIONER STRACHAN: I think that  
21 is all I have, thank you.

22 COMMISSIONER VAN WART: Mr. Chairman,  
23 the first question deals with 151A which is submitted,  
24 the British Columbia Dental Association. Has the  
25 legislation been passed enabling you to put this into  
26 force?

27 DR. MUNSIE: Legislation is not  
28 required. It has to be registered and carried through the  
29 Superintendent of Insurance Brokers in Victoria. We  
30 were given to believe, in a very recent communication,  
this is just about reality.

COMMISSIONER VAN WART: I see. Turning





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4 to Section 161, which was spoken of before, you say the  
5 cost of proposed dental plan for the average child up to  
6 and including age 15 will be approximately \$70 per year  
7 initially and \$40 per year thereafter. A family of  
8 three children, that would be \$210, the initial cost for  
9 the three children under 15, and \$120 subsequently.

10 Well, with people paying for their  
11 medical insured care now and adding that cost, do you  
12 think it is realistic that you will sell much insurance  
13 under this plan?

14 DR. MUNSIE: Sir, again we have - we  
15 refer to plans which are, similar plans, which are  
16 operating in the State of Washington, State of Oregon  
17 and State of California, and they have proved to be  
18 eminently successful in this regard. Here again I would  
19 like to emphasize what Dr. Slakov said; the difficulties;  
20 these figures are only taken from the experience they  
21 have had in this regard and we have tried to relate them  
22 to what might be expected here.

23 I really cannot add more than that to  
24 your question, sir.

25 COMMISSIONER VAN WART: If these areas  
26 where you say it was done, I wonder if this is the high  
27 income bracket group of patients who are availing them-  
28 selves of this service rather than the low income?

29 DR. MUNSIE: I can't say.

30 DR. SLAKOV: Dental needs, Mr. Commis-  
sioner, are rather unique in this health field in that  
almost 100% of people require dental services at one  
time or another and therefore the principle of true



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3 insurance does not apply to dental needs.

4 This may be one of the very valid  
5 reasons why dental prepaid plans have been so late in  
6 starting and so slow in development.

dpw 7 In other words, this is not true  
8 insurance. This is simply a matter of averaging or  
9 budgeting the costs for a group of people. There is  
10 no insurance company that we are aware of. No private  
11 insurance company that will undertake private individual  
12 coverage of dental needs because of the expense.

13 Furthermore, because each individual  
14 person is to some degree able to judge his own needs,  
15 and therefore only the people in the greatest need  
16 would wish to join such a program, which would subse-  
quently again raise the premiums.

17 In general, to answer the cost problem,  
18 I might say that we feel that even a group program would  
19 hardly be attractive to a group of recipients except if  
20 they could arrange for some form of aid or subsidy or  
participation with some other third party.

21 COMMISSIONER VAN WART: Following along  
22 just from another angle, do you anticipate with the  
23 successful campaign of fluoridation that these rates  
24 would be able to be cut down?

25 DR. SLAKOV: Very definitely so.

26 COMMISSIONER VAN WART: How many years  
27 would you anticipate it would take before you feel the  
effect generally of fluoridation?

28 DR. SLAKOV: In studies made, it seems  
29 that between six and eight years must pass before a  
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3 substantial evidence of dental caries, the lowering of  
4 the rate of dental caries is shown.

5 COMMISSIONER VAN WART: Well then, it  
6 would be more feasible for you to start such a plan in  
7 an area that has fluoridation; would it not?

8 DR. SLAKOV: Yes, sir.

9 COMMISSIONER VAN WART: Than an area  
10 without fluoridation?

11 DR. SLAKOV: That is quite correct.  
12 That could well be. We have at this time not considered  
13 any particular area, because as our Chairman has stated  
14 the stage of progress in which this program rests is  
15 with the legislative end in Victoria.

16 COMMISSIONER VAN WART: Have you given  
17 any thought to what age group of children you should  
18 start with? Up to eight, or ten, or four? Have you  
19 given that any thought?

20 DR. SLAKOV: Yes, sir. That is a very  
21 concrete part of our proposal to the Government that the  
22 younger age groups be given definite priority, up to the  
23 age of 15, as we envisage it in our program. There are  
24 many good reasons for this. Amongst them is the fact  
25 that these children are available in schools at this  
26 time, and they are more accessible to both actuarial  
27 study and subsequent statistical studies.

28 Another point is that most parents  
29 would be very anxious to have their children cared for,  
30 even ahead of themselves in most cases.

Another point is that this is the age  
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4 would have its greatest effect, and would be evident in  
5 better dental health in that individual as he grows into  
6 adulthood.

7 COMMISSIONER STRACHAN: In this connec-  
8 tion, what would be the frequency of your examinations?

9 DR. SLAKOV: We have tentatively  
10 figured on two examinations annually.

11 COMMISSIONER STRACHAN: For all those  
12 age groups?

13 DR. SLAKOV: For all the participants.

14 COMMISSIONER STRACHAN: Would that  
15 include peridental examination?

16 DR. SLAKOV: It probably would, sir,  
17 and prophylaxis as necessary by judgment of the indivi-  
18 dual dentist.

19 COMMISSIONER VAN WART: That would be  
20 on the principle of a physical check-up, which the  
21 medical group say is not insurable?

22 DR. SLAKOV: That is correct, and again  
23 I must say that dentistry, as a whole, is not truly  
24 insurable. However, in this approximate figure as a  
25 premium that we have given you, this would include check-  
26 ups, x-rays, and any subsequent care that would be neces-  
27 sary.

28 COMMISSIONER STRACHAN: X-rays at all  
29 ages, I presume?

30 DR. SLAKOV: That is correct.

COMMISSIONER VAN WART: That is in  
your \$70 figure?

DR. SLAKOV: That is correct.



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COMMISSIONER STROGAN: Now, that

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DR. SLAKOV: It probably would, sir,

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COMMISSIONER VAN WERT: What would be

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4 COMMISSIONER VAN WART: Coming to  
5 another matter, it is more for information, and also I  
6 have not had an opportunity of reading the submission  
7 you gave us today, and it may be all explained in that.

8 It is on page 5, No. 15. It is with  
9 regard to the dental technicians from whom we are going  
10 to hear a brief, and whose brief I have read.

11 You make the statement that certain  
12 sections of their legislation were declared "ultra vires".  
13 Would you enlarge on that part of the section so I will  
14 understand.

15 DR. MUNSLIE: Yes, sir. The Dental  
16 Technicians' Act, as passed in 1958, provided for a Board  
17 to be established to determine the conditions of dental  
18 technology and the area in which they might work. The  
19 Board at that time issued licences to some 50-odd dental  
20 technicians to do complete upper and lower dentures.

21 As a means of finally having this group  
22 finally eliminating this practice, there were to be no  
23 new licences issued after a certain date, and the Supreme  
24 Court of British Columbia, by application of another dental  
25 technician not included in this group, declared the  
26 legislation ultra vires, and there is now no such legis-  
27 lation on the books allowing this practice to be carried  
28 on. Does that answer your question?

29 COMMISSIONER VAN WART: That is, those  
30 dentists who were denturists, who were licensed by virtue  
of carrying on a practice for so many years, the legisla-  
tion pertaining to them was declared ultra vires?

DR. MUNSLIE: That is, correct, sir.



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another matter, it is more for information, and also I have not had an opportunity of reading the submission you gave us today, and it may be an explanation in that. It is on page 5, No. 15. It is with regard to the dental technicians from whom we are going to hear a brief, and whose brief I have read.

You make the statement that certain

sections of their legislation were declared "ultra vires". Would you enlarge on that part of the section as I will understand.

DR. MUNSLIE: Yes, sir. The Dental

Technicians' Act, as passed in 1950, provided for a Board to be established to determine the conditions of dental technology and the area in which they might work. The Board at that time issued licences to some 1500 dental technicians to do complete upper and lower dentures. As a means of finally having this group

finally eliminating this practice, there were to be no new licences issued after a certain date, and the Supreme Court of British Columbia, by a decision of another dental technician not included in this group, nullified the legislation ultra vires, and there is now no such legislation on the books allowing this practice to be carried on. Does that answer your question?

COMMISSIONER VAN WART: That is, those

dentists who were denturists, who were licensed by virtue of carrying on a practice for so many years, the legislation pertaining to them was declared ultra vires?

DR. MUNSLIE: That is correct, sir.





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4 COMMISSIONER VAN WART: What is the  
5 position of a new person coming into a community to  
6 practise?

7 DR. MUNSIE: There is no provision,  
8 sir.

9 COMMISSIONER VAN WART: The Act was a  
10 special Act, then, licensing those who had been practising  
11 formerly?

12 DR. MUNSIE: No, sir. The Act was to  
13 licence dental technicians operating in the normal manner  
14 providing prosthetic appliances under the prescription of  
15 a dentist. This was the purpose of the Dental Technicians'  
16 Act, to meet the situation as it existed at the time,  
17 where people were practising dentistry without licences.  
18 They passed a provision, No. 10, with the rules and regu-  
19 lations and this was declared ultra vires by the Supreme  
20 Court of British Columbia.

21 COMMISSIONER VAN WART: But a dental  
22 technician now working with a dentist can legally prac-  
23 tise under the Act?

24 DR. MUNSIE: That is correct, sir.

25 COMMISSIONER VAN WART: But it was  
26 this group who were brought in and were practising indepen-  
27 dently -- that section of the Act was declared ultra  
28 vires for them?

29 DR. MUNSIE: That is correct, sir.

30 COMMISSIONER VAN WART: Thank you.

COMMISSIONER BALTZAN: I am not going  
to keep you, but I must tell you I am very much troubled  
by the evidence produced in an extraordinarily well-

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3 documented brief in another province. It is stated that  
4 95% of the general population needed preventive and/or  
5 therapeutic care. What is your experience, sir?

6 DR. MUNSIE: I would say this is true.

7 COMMISSIONER BALTZAN: No. 2 in that  
8 same brief, and my figures are not just exactly right,  
9 but the point is this: it was said that of the people  
10 who were close to dentists - there was no trouble about  
11 getting to see a dentist, and they had the private means  
12 to do so, only 28% took advantage of it, with both the  
13 ability to pay and accessibility to dentists.

14 DR. MUNSIE: I would say that that  
15 figure is quite a bit on the low side, sir.

16 COMMISSIONER BALTZAN: Well, now then,  
17 another interesting thing, and it has been troubling me,  
18 and that is that people also with very close proximity  
19 to dentists, and they had social assistance -- I do not  
20 like to call it "free dentistry" -- but only 34% of those  
21 people went to see a dentist, even though there were  
22 enough dentists and even though they had this thing that  
23 they were looked after and would not have to look after  
24 it themselves.

25 DR. MUNSIE: I would say this is  
26 probably very close to it.

27 COMMISSIONER BALTZAN: Just quickly  
28 and roughly; for those who have dentists and those who  
29 have the means one way or another, one-third of the  
30 people take advantage of going to see a dentist?

DR. MUNSIE: I think, sir, you are  
taking it under the social assistance as 34%.



documented brief in another province. It is stated that 85% of the general population needed preventive and/or therapeutic care. What is your experience, sir?

DR. MURPHY: I would say this is true.

COMMISSIONER BARTON: No, I in that

same brief, and my figures are not just exactly right, but the point is this: it was said that of the people who were close to dentists - there was no trouble about getting to see a dentist, and they had the private means to do so, only 18% took advantage of it, with both the ability to pay and accessibility to dentists.

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another interesting thing, and it has been troubling me, and that is that people also with very close proximity to dentists, and they had social assistance -- I do not like to call it "free dentistry" -- but only 34% of those people went to see a dentist, even though there were enough dentists and even though they had this thing that they were looked after and would not have to look after

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4 COMMISSIONER BALTZAN: Yes, something  
5 like that.

6 DR. MUNSIE: I believe the majority of  
7 those would be in an age group where they possibly did  
8 not require the same dental services as the overall  
9 population. I do not think it would be fair to say that  
10 35% of people having the means and availability of dental  
11 services are not making use of them. I think that  
12 figure would be higher. It is true that only a third  
13 of the people are being treated, but there are other  
14 reasons for this.

15 COMMISSIONER BALTZAN: Thank you very  
16 much. That reduces my troubles considerably.

17 I am still thinking that while they  
18 have all these things, there is not the dollar question  
19 and there is not the other things I have referred to,  
20 and it is not due to the fact you are not doing your  
21 very best to educate the public, and I know mothers do  
22 a lot for you by getting their children to go to the  
23 dentist; in spite of that, we must still take in some  
24 blocking factor: the human factor?

25 DR. MUNSIE: Yes, I think that is true.  
26 I think the education you mentioned is most important  
27 in this regard. We find that in the different generation  
28 we find the utilization of dental service is much higher  
29 in the recent generation, in the children coming along  
30 now. There are many more getting dental treatment now  
than in the preceding generation.

Education is so necessary in any health  
program and it is particularly necessary in a dental



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DR. MUNSIE: I believe the majority of those would be in an age group where they possibly did not require the same dental services as the overall population. I do not think it would be fair to say that 82% of people having the means and availability of dental services are not making use of them. I think that figure would be higher. It is true that only a third of the people are being treated, but there are other reasons for this.

COMMISSIONER LATTAN: Thank you very much. That reduces my troubles considerably. I am still thinking that while they have all these things, there is not the dollar question and there is not the other things I have mentioned to, and it is not due to the fact you are not doing your very best to educate the public, and I know whether do a lot for you by getting their children to go to the dentist in spite of that, we may still take in some bleeding factors the human factor?

DR. MUNSIE: Yes, I think that is true. I think the education you mentioned is most important in this regard. We find that in the different generation we find the utilization of dental service is much higher in the recent generation, in the children coming along now. There are many more getting dental treatment now than in the preceding generation.

Education is so necessary in any health program and it is particularly necessary in a dental





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3 health program, whether it be by the dental profession  
4 or any other group interested in this problem.

5 COMMISSIONER BALTZAN: You have just  
6 as much trouble to lead the horse to the trough as to  
7 make him drink?

8 DR. MUNSIE: That is correct, sir.

9 THE CHAIRMAN: Thank you very much,  
10 gentlemen. Your representations have been received  
11 and will have our consideration.

12 DR. MUNSIE: Thank you, sir.  
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4 THE CHAIRMAN: We will now have the  
5 submission of the Public Denturists' Society of British  
6 Columbia.

7 --- EXHIBIT NO. 152: Submission of The Public Denturists'  
8 Society of British Columbia.

9 SUBMISSION OF THE PUBLIC DENTURISTS' SOCIETY  
10 OF BRITISH COLUMBIA

11 Appearances: Mr. Gerry Smith  
12 Mr. Owen Mason  
13 Mr. Ralph Buttress

14 THE CHAIRMAN: Mr. Smith?

15 MR. SMITH: Mr. Chairman, my name is  
16 Gerry Smith. I am a past President of the Public Dentu-  
17 rists' Society of British Columbia. I am a member of the  
18 Government Dental Technicians' Examining Board. My  
19 associates are Mr. Ralph Buttress, the Director of the  
20 Public Denturists' Society of British Columbia and Mr.  
21 Owen Mason, a consultant with the Public Denturists'  
22 Society of British Columbia.

23 It is not my intention to read this  
24 lengthy brief, but I would like to read about three  
25 paragraphs of explanation.

26 The purpose of this Brief is primarily  
27 to familiarize the Commission with the services offered  
28 by the Public Denturist, as well as to stress the need  
29 of governmental assistance in Dental Services.

30 The force of public opinion in British  
Columbia induced the government of this province to intro-  
duce legislation permitting the public to deal directly





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THE CHAIRMAN: Mr. Smith?

MR. SMITH: Mr. Chairman, my name is Gerry Smith. I am a past President of the Public Denturists' Society of British Columbia. I am a member of the Government Dental Technicians' Examining Board. My associates are Mr. Ralph Buttress, the Director of the Public Denturists' Society of British Columbia and Mr. Owen Mason, a consultant with the Public Denturists' Society of British Columbia.

It is not my intention to read this lengthy brief, but I would like to read about three paragraphs of explanation.

The purpose of this brief is primarily to familiarize the Commission with the services offered by the Public Denturist, as well as to stress the need of governmental assistance in Dental Services.

The force of public opinion in British Columbia induced the government of this province to introduce legislation permitting the public to deal directly



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3 with the Licensed Dental Technician. The success of  
4 this legislation, from the public standpoint, has been  
5 remarkable.

6 Should the Commission believe that a  
7 shortage of dentists or the cost factor for reconstruc-  
8 tions, or both, would interfere with the success of a  
9 dental health scheme, then we believe it would do well  
10 to investigate this field of dental care offered by the  
11 Public Denturist.

12 not denied herein. The best interests of all concerned  
13 has been achieved by separating the surgical and preven-  
14 tative fields of dentistry from the prosthetic or denture  
15 field.

16 We feel this procedure must be followed  
17 to assure the success of any dental health scheme.

18 Now, I would like to call on Mr.  
19 Mason to just bring out some of the highlights of the  
20 brief that we submitted.

21 MR. MASON: Mr. Chairman and members  
22 of the Commission, it was our understanding, and we  
23 trust you have done your homework, so we did not prepare  
24 any written summary. I am now quoting from memory, and  
25 no doubt you will have a number of questions to ask.

26 dental care would be. The brief might be called, the first  
27 part of it, mildly controversial, and, to quote a former  
28 witness before you, horribly controversial.

29 I will deal, first, with the mildly  
30 controversial part. We started out with the assumption  
that the matter of health care for the Canadian people  
would be a matter of priority. In other words, we



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4 started off with the assumption that the Canadian Federal  
5 Government is going to supply additional funds and it  
6 will be a political question of how many funds will be  
7 available.

8 The second problem which is our concern  
9 is what you might call the medical aspect of it; where  
10 are those funds going to go? We did a little research,  
11 because the funds of this organization are limited. We  
12 found out that by and large the low income groups were  
13 not denied access to physicians or to hospital care.

14 In other words, the pattern of medical  
15 treatment seemed to be the same or roughly the same  
16 irrespective of the income of the groups concerned.

17 The reverse was true when it came to  
18 the field of dentistry. In other words, there seemed to  
19 be a direct correlation between income and dental care.  
20 So that seemed to indicate to us that the need for dental  
21 care for a government scheme is far more urgent, although  
22 it may be less glamorous than the need for government  
23 support for medical care.

24 Now, the next point, I think, which is  
25 well worth dealing with, and some mention has been made  
26 of it, and that is the question of whether a scheme of  
27 dental care should be part and parcel of any federal  
28 program.

29 Now, it is our belief, based upon human  
30 nature, that it is vitally important that a dental health  
31 scheme should be part of any health program which may be  
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33 if it is decided only to introduce a medical scheme at



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3 this time, then what we fear will happen will be this:  
4 that an initial sum of so many million dollars will be  
5 forthcoming from the Federal Government, and as the  
6 experience in Britain shows the cost of such a scheme  
7 will probably increase year by year and therefore it  
8 will be a physical or political impossibility to introduce  
9 on top of that a scheme covering dental health for many,  
10 many years to come.

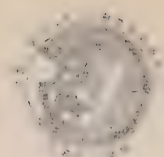
11 We say that having in mind the magnitude  
12 of the costs which are likely to be involved for any  
13 comprehensive scheme of dental care, because the figures  
14 that we have looked at seem to indicate that in the first  
15 year or two years of the British scheme, cost of the  
16 dental scheme exceeded that of general medical care.

17 So, it is our belief that any scheme  
18 or health scheme which may be put forward by the Federal  
19 Government must make provision for dental care in it.

20 We then come to the controversial part  
21 of our submission, and that is this: when a comprehensive  
22 dental scheme is introduced, the greatest demand will be  
23 for denture work. If you look at page 18 of our submis-  
24 sion, it indicates that for the first year of the  
25 National Health Scheme in Great Britain, the cost of  
26 denture work was 31 million pounds, as compared with  
27 only 8 million pounds for what might be called surgical  
28 or preventive dentistry.

29 Now, it is our belief that the dental  
30 profession is completely incapable of handling the volume  
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We say that having in mind the magnitude of the costs which are likely to be involved for any comprehensive scheme of dental care, because the figures that we have looked at seem to indicate that in the first year of the scheme the cost would be very high.

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3 supply dentures to the public.

4 Now, this is not our opinion alone;  
5 there are two main reasons for so assuming. One, of  
6 course, is this, that you cannot sell an article or  
7 provide an article to the public that is completely  
8 unsatisfactory.

9 Dental technicians have been serving  
10 the public in this province for many, many years and  
11 studies have been made to indicate that perhaps half or  
12 even more of all the dentures supplied in this province  
13 have been provided in contravention of the Dentistry Act.

14 Secondly, I would say now that a  
15 number of medical men have agreed that a trained dental  
16 technician can take in persons and complete the whole  
17 process of making dentures, including the fitting, without  
18 endangering the health of the public.

19 We refer to the stand of Major-General  
20 Halliwell in England and also we might say to you at  
21 this time that on a number of occasions the dentists in  
22 this country also come to the same conclusion, their  
23 profession notwithstanding. For instance, I think I  
24 might just quote to you - I can give you the name of the  
25 dentist afterwards, but it was said to the Annual Dental  
26 Association Meeting in one of the provinces here, and he  
27 said, and this is a direct extract from the minutes of  
28 the meeting:

29 "The time is coming when dental mechanics  
30 will be permitted legally to make full  
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6 Now, the time is getting short and I  
7 assume you have read the brief and we are open to any  
8 questions there may be.

9 THE CHAIRMAN: When and where was that  
10 statement made that you just read?

11 MR. MASON: It was made to the Annual  
12 Alberta Dental Association Meeting and it was made in  
13 1950. The remarks of the dentist concerned came true  
14 because I believe it is correct they are now licensed  
15 in Alberta.

16 MR. SMITH: That is true.

17 COMMISSIONER BALTZAN: I have no  
18 questions.

19 COMMISSIONER GIRARD: I have no ques-  
20 tions.

21 COMMISSIONER STRACHAN: I would like to  
22 make one observation and one assertion. I think I am  
23 reliably informed that the lengthy quotation attributed  
24 to Major-General Halliwell was a minority report, from a  
25 group of 15 members with a minority report of one by this  
26 individual.

27 The assertion which I would like to  
28 make is regarding the second sentence on page 19, para-  
29 graph 51 wherein it is stated:

30 "There would be less indiscriminate  
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4 This is close to a libellous accusation  
5 and though it is generalized it must apply personally.  
6 If I may say so at this moment may God strike me dead  
7 if I have ever extracted a tooth without good reason  
8 and certainly never for the profit motive.

9 I think I speak for the rest of the  
10 dental profession of Canada.

11 MR. MASON: May I make this one obser-  
12 vation? I am sorry if I have offended any member of the  
13 Commission. We were referring there particularly to the  
14 experience in Great Britain under the National Health  
15 Scheme and I think there is a commission of inquiry  
16 which has established to their satisfaction that there  
17 had been perhaps more extractions of teeth and fitting  
18 of dentures that would otherwise have occurred if there  
19 had been an adequate supply of dentists to cope with the  
20 demand.

21 It was certainly not intended to  
22 reflect on the dental profession as a whole in Canada.

23 COMMISSIONER STRACHAN: My only answer  
24 to that is we are dealing with dentistry in Canada and  
25 not in Great Britain.

26 COMMISSIONER VAN WART: Turning to  
27 page 18 of your brief where you quote the statistics of  
28 1948: "Prior approval" and so on. Have you noticed the  
29 figures of the prior approval, the percentages have  
30 fallen gradually and the percentages of other work have  
gradually increased which would indicate, to my mind,  
that less extractive work and more preventive work is  
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6 figure is for the first two years reflecting an unprece-  
7 dented demand for dentures for people who could not  
8 afford them. I also believe the encouraging figures  
9 for other work reflect the fact that having had this  
10 free dental scheme, while it was free in the beginning,  
11 that the general public became more closely in contact  
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14 In other words, the scheme was educa-  
15 tional as well as merely providing for dental work and  
16 I think that those figures were probably - I do not have  
17 them for 1953 or 1954 but I would assume that that is a  
18 trend which would continue that once a person is accus-  
19 tomed to dental care then it sort of spreads and, as I  
20 say, I think the provision of the free dental scheme in  
21 Great Britain has resulted in a remarkable degree of,  
22 shall we say, an increase in preventive and surgical  
23 denture work.

24 THE CHAIRMAN: What do you say about  
25 the suggestion from Dr. Strachan that General Halliwell's  
26 report is merely an individual report and not part of  
27 the report as such?

28 MR. MASON: As I understand it, Mr.  
29 Chairman, this document was supplied to me as an opinion  
30 by Major-General J.P. Halliwell. Perhaps the word  
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4 We merely put that in to indicate  
5 that not all members of the medical or dental profession  
6 disagree with the contention that the dental technician  
7 is qualified to do this work.

8 THE CHAIRMAN: What is the situation  
9 in British Columbia now, the legal basis for operation?

10 MR. MASON: I might make one observa-  
11 tion and then turn it over to Mr. Smith because he is  
12 the most familiar with it.

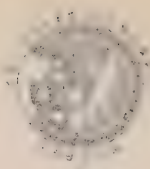
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18 MR. SMITH: That is certainly my  
19 opinion and it must have been the opinion of the majority  
20 of our Board, otherwise there would not be 62 licences  
21 issued.

22 THE CHAIRMAN: What is this business  
23 of the Court declaring part of the Act ---

24 MR. SMITH: That is true, the Court  
25 declared Division 10 of the regulations, not the Act,  
26 which was drawn up by the Board. The Court declared  
27 them ultra vires and he gave several reasons and among  
28 these reasons was danger to restriction; there was no  
29 provision made for any future dental technician to work  
30 as we were licensed to work. That was his main criti-  
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6 this session that it will be straightened out.

7 Certainly I can only express a personal  
8 opinion on this but I think you will find it will be  
9 straightened out in such a way that other technicians  
10 who, in the past, were excluded from this will have the  
11 opportunity of qualifying and becoming licensed.

12 As I say, it is only a personal opinion.

13 MR. MASON: I think if I recollect  
14 the position of the learned judge, it was to this effect,  
15 and it seems to bear out the observation made a little  
16 earlier that the intent of the Legislation was to enable  
17 us to facilitate dental technicians dealing directly  
18 with the public and because of the fact that the regula-  
19 tions existed that no more would be licensed after a  
20 certain date.

21 Then, of course, that was against the  
22 intent of the Act which seems to indicate what the  
23 fundamental purpose of the legislation was.

24 THE CHAIRMAN: Who attacked the validity  
25 of the regulation?

26 MR. SMITH: A member of the Dental  
27 Society who was unable to qualify due to the number of  
28 years required, to prove the number of years of practice  
29 required. He was unable to satisfy the Board and, conse-  
30 quently, was not issued a licence so he took it to the  
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3 dealing directly with the public and who, if they established  
4 they had been doing that for a period of 12 years, with  
5 seven in British Columbia, they would receive what is  
6 called a special licence and there could only be a  
7 limited group who had practised 12 years and seven years  
8 in British Columbia who received those special licences  
9 which permitted them to produce, reproduce, construct,  
10 furnish, supply or alter. That was all they were  
11 allowed to do, partial dentures and so on and they must  
12 have a prescription from a dental surgeon.

12 MR. SMITH: That is right.

2 13 COMMISSIONER McCUTCHEON: And in order  
14 to make sure that people passed the regulations, in order  
15 to put some time limit so there would be some availability  
16 of proof as to the group they were looking after they  
17 said they would not licence anybody after the 15th of  
18 December, 1960.

18 THE CHAIRMAN: It all makes sense.

19 COMMISSIONER McCUTCHEON: So the  
20 situation is that now any of your procedures must be  
21 done on the prescription of a dental surgeon and you  
22 are not authorized to deal with the public.

23 MR. SMITH: That is a point that could  
24 bear a lot of discussion but probably legally it is true.

25 COMMISSIONER McCUTCHEON: I am only  
26 interested in the legal position.

26 MR. SMITH: For instance, the 62 who  
27 were licensed have continued to operate without any  
28 interference from the authorities.

29 COMMISSIONER McCUTCHEON: In other  
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3 words, there is a certain group who are continuing as  
4 though Regulation 10 had not been declared ultra vires?

5 MR. SMITH: That is true.

6 COMMISSIONER McCUTCHEON: I won't  
7 attempt to draw any conclusion.

8 THE CHAIRMAN: Thank you very much,  
9 gentlemen.  
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4 In the province THE CHAIRMAN: The next brief will  
5 be that of The Canadian Public Health Association, B.C.  
6 Division and the Canadian Institute of Sanitary Inspec-  
7 tors.

8 THE SECRETARY: That will be Exhibit  
9 No. 153.

10 --- EXHIBIT NO. 153: Submission of The Canadian Public  
11 Health Association, B.C. Division  
12 and the Canadian Institute of  
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14 SUBMISSION OF THE CANADIAN PUBLIC HEALTH ASSOCIATION,

15 B.C. DIVISION AND THE CANADIAN INSTITUTE OF

16 SANITARY INSPECTORS

17 Appearances: Mr. D.A. Geekie  
18 Dr. M.W. McLean  
19 Dr. D. Yeo  
20 Miss Trenna Hunter  
21 Miss R. Ross  
22 Mr. A.C. Dobson  
23 Dr. C.J.G. Mackenzie  
24 Dr. J.H. Smith  
25 Mr. J.F. Webb

26 MR. GEEKIE: I would like to introduce  
27 Dr. M.W. McLean, Dr. D. Yeo, Miss Trenna Hunter, Miss R.  
28 Ross, Mr. A.C. Dobson, Dr. C.J.G. Mackenzie, Dr. J.H.  
29 Smith and Mr. J.F. Webb.

30 I will now read the brief.

1. The B.C. Branch of the Canadian  
Public Health Association is an accredited affiliate of  
the Canadian Public Health Association - a voluntary  
organization of the professional personnel engaged in  
Public Health work in Canada. It is composed of 269  
active members presently engaged in public health work





No. 138.



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3 in this province by both official and voluntary health  
4 agencies. The membership includes physicians, nurses,  
5 sanitarians, veterinarians, dentists, health educators  
6 and laboratory personnel.

7 3. The Association wishes to discuss  
8 matters of particular interest to its membership, accor-  
9 ding to the terms of reference of the Commission, and  
10 with particular reference to items that, due to political  
11 and/or other connotations, may not be presented in  
12 official agency presentations to the Commission.

13 4. The material herein contained is  
14 a compilation of the personal deliberations of the  
15 Association's membership only, and is in no way intended  
16 to represent the thinking, policy, etc., of the agencies  
17 that the membership is employed by, or of any other  
18 organization or individual.

19 RECOMMENDATIONS

20 5. That primary and secondary preven-  
21 tion of disease and disability be made the very foundation  
22 of any health care program in Canada.

23 6. That the above philosophy (see 5)  
24 be made much more predominant in the training of all  
25 "Health Personnel" - physicians, nurses, dentists etc.

26 7. That the public finances made  
27 available for Health Services be budgeted more in  
28 keeping with the priorities of the above rather than the  
29 present practice of allotting the available funds for the  
30 alleviation, cure or control of those conditions most  
widely recognized by the public or professions as  
requiring treatment at the present time.



in this province by both official and voluntary health agencies. The membership includes physicians, nurses, sanitarians, veterinarians, dentists, health educators and laboratory personnel.

3. The Association wishes to discuss matters of particular interest to its membership, according to the terms of reference of the Commission, and with particular reference to items that, due to political and/or other considerations, may not be presented in official agency presentations to the Commission.

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### RECOMMENDATIONS

5. That primary and secondary prevention of disease and disability be made the very foundation of any health care program in Canada.

6. That the above philosophy (see 5) be made much more predominant in the thinking of all

7. That the public finances made available for Health Services be budgeted more in keeping with the priorities of the above rather than the present practice of allocating the available funds for the alleviation, cure or control of those conditions most widely recognized by the public or professions as requiring treatment at the present time.





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4 8. That steps be taken to assure  
5 that all public health personnel are properly trained -  
6 in keeping with the demands of the service they are to  
7 render to the public. I might add, at the present time.  
8 The membership feels that there are at least two areas  
9 of acute lacking in the post-graduate and in service  
10 training programs presently available in British Columbia.

11 A. Public Health programs, and  
12 problems, of today, invariably require  
13 a team approach that involves a variety  
14 of disciplines. At the present time  
15 the majority of these disciplines  
16 receive original professional training  
17 completely separated from each other,  
18 consequently the team approach by  
19 these disciplines is always, to some  
20 degree, a superimposed philosophy.  
21 The Association would thus like to  
22 recommend that the Schools of Public  
23 Health, Schools of Nursing, etc., be  
24 encouraged to give further consideration  
25 to the possibility of more joint  
26 training of the various disciplines  
27 engaged in the "Public Health Team".

28 B. That opportunities, without finan-  
29 cial loss to the individual, be made  
30 available to more senior field personnel  
for further study, training and "foreign  
experience".

9. It is widely recognized that the



8. That steps be taken to assure

that all public health personnel are properly trained - in keeping with the demands of the service they are to render to the public. I might add, at the present time, The membership feels that there are at least two areas of acute lacking in the post-graduate and in service training programs presently available in British Columbia.

A. Public Health programs, and problems, of today, inevitably require a team approach that involves a variety of disciplines. At the present time the majority of these disciplines are completely separated from each other, consequently the team approach by these disciplines is always, to some extent, a makeshift one. The Association would like to recommend that the Council of Public Health, British Columbia, etc., be encouraged to give further consideration to the possibility of more joint training of the various disciplines engaged in the "Public Health Team". 3. That opportunities, without financial cost to the individual, be made available to more senior field personnel for further study, training and "foreign experience". 9. To be widely recognized that the



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4 calibre and quality of service rendered by public health  
5 agencies is dependent almost entirely on the calibre of  
6 professional personnel available to render those services.  
7 If we are to attract and hold the high calibre, well-  
8 trained personnel required (to carry on a dynamic and  
9 effective public health program) we must be prepared to  
10 provide them with a status and remuneration equal to  
11 other comparable professions in the area. At the present  
12 time the Public Health Worker in British Columbia is at  
13 a disadvantage both status and financial-wise with his  
14 fellow professionals of equal training and responsibility.  
15 There is also great variance in these factors depending  
16 on the location within which the worker is employed and  
17 the employing agency. These factors tend to produce  
18 staffs that are composed of varying mixtures of individuals  
19 who are "local medical missionaries, young workers desi-  
20 ring only the necessary experience to go on to more  
21 rewarding employment, third-rate performers, individuals  
22 who because of age or circumstances are trapped to their  
23 present employment and "competent dedicated public health  
24 workers". The Association recommends that the Commission  
25 give particular study to this opinion of its membership  
26 with a view of presenting an independent opinion on this  
27 problem.

28 We will omit No. 10 since it has been  
29 covered in the dental section.

30 11. That all steps be taken so as to  
obtain the maximum benefit, for the people of British  
Columbia, from the proven ability of water fluoridation  
to prevent dental decay. Specifically:





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who because of age or circumstances are forced to their present employment and "competent dentists and health workers". The Association recommends that the Commission give particular study to this problem of the remuneration with a view of presenting an independent opinion on this problem.

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11. That all steps be taken so as to obtain the maximum benefit for the people of British Columbia, from the proven ability of water fluoridation to prevent dental decay. Specifically

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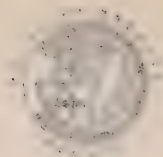


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4 A... That the Federal and Provincial  
5 Governments provide the necessary  
6 stimulation, financial and otherwise,  
7 for the formation of a voluntary health  
8 agency whose specific terms of reference  
9 would include the promotion of water  
10 fluoridation for the prevention of  
11 dental decay - primarily via public  
12 education.

13 B... Failing to have the decision re  
14 the fluoridation of public water  
15 supplies returned to the jurisdiction  
16 of responsible government, the Associa-  
17 tion recommends that steps be taken  
18 to allow a simple majority rule in  
19 public referendums regarding this issue.

20 C. That the senior governments be  
21 encouraged to issue concise clear  
22 leadership in favour of water fluorida-  
23 tion, including financial assistance  
24 for those communities requiring same  
25 for the installation of the necessary  
26 equipment.

27 12. This Association recognizes the  
28 fact that in a democratic society the success of public  
29 health services depends to a very large extent, in fact  
30 almost entirely, on public acceptance of the services  
concerned. This in turn depends to a very large extent  
on public recognition and understanding of the value and  
availability of these services. This all important



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A. That the Federal and Provincial Governments provide the necessary stimulation, financial and otherwise, for the formation of a voluntary health agency whose standing terms of reference would include the provision of water fluoridation for the prevention of dental decay - especially in children education.

8. Failing to have the decision re the fluoridation of tap water supplies referred to the jurisdiction of a responsible government, the Association then recommends that steps be taken to allow a single authority rate in public referendums regarding this issue.

9. That the senior government be encouraged to issue codes of leadership in favour of water fluoridation, including financial assistance for those communities requiring same for the installation of the necessary equipment.

12. This Association recognizes the fact that in a democratic society the success of public health services depends to a very large extent, in fact almost entirely, on public acceptance of the services concerned. This in turn depends to a very large extent on public recognition and understanding of the value and availability of these services. This is an important





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3 function of all public health workers - the prevention  
4 of disease and improvement of the public's health through  
5 public understanding and thus action is commonly referred  
6 to as public health education. Of all public health  
7 activities this area is most in need of extensive  
8 research and evaluation - particularly those aspects of  
9 the program that are carried out en masse. This area  
10 of activity is also one that requires the highest degree  
11 of co-operation between the official and voluntary health  
12 agencies. To this end this Association recommends that  
13 steps be taken to improve this phase of public health  
services, specifically:

14 A. That the bi-annual National Public  
15 Health Education Conference sponsored  
16 by the Department of National Health  
17 and Welfare, be extended to include  
18 the major voluntary health agencies,  
19 the university schools of education and  
20 physical and health education, the  
21 schools of public health, major news-  
22 paper, health and medical reporters,  
23 TV and radio health broadcast producers  
and others directly concerned with this  
area of endeavour.

24 B. That this body be encouraged to  
25 promote, and it should be, if necessary,  
26 to undertake basic research in the  
27 field of health education with parti-  
28 cular emphasis on the area of evaluation  
29 of mass education programs.  
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function of all public health workers - the prevention of disease and improvement of the public's health through public understanding and thus action is normally referred to as public health education. Of all public health activities this area is most in need of extensive research and evaluation - particularly those aspects of the program that are oriented out on mass. This area of activity is also one that requires the highest degree of co-operation between the official and voluntary health agencies. To this end this Association recommends that steps be taken to improve this phase of public health services, specifically:

A. That the National Association of Public Health Administrators

by the Department of National Health and Welfare, be extended to include the major voluntary health agencies, the university schools of education and physical and health education, the schools of public health, major newspaper, health and medical journals, TV and radio health broadcast programs and others directly concerned with this

A. That this body be encouraged to promote, and if necessary, to undertake basic research in the field of health education with particular emphasis on the area of evaluation of mass education programs.



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4 12c. The Association feels that it is  
5 imperative that local mental health services be extended  
6 immediately to all areas in the province to assist and  
7 augment the work of the public health nurse, the health  
8 unit directors, and the physicians in private practice.  
9 These services should be directed primarily towards the  
prevention of mental illness in all its phases.

10 12d. The Association wishes to commend  
11 the present trend in British Columbia to provide home  
12 nursing services to the majority of our people. We urge  
13 that the Commission lend its support to this trend so as  
14 to have it furthered as quickly as possible and that it  
15 be augmented by the provision of male nurses in all areas,  
16 as well as Homemakers' Services in those areas showing a  
17 need therefor. These services should be followed as soon  
18 as possible by the provision of rehabilitation personnel  
19 such as physiotherapists, occupational therapists, speech  
20 therapists, and recreational therapists in sufficient  
21 numbers to serve the needs of the community.

22 12e. Good occupational health services  
23 are now regarded as a normal function of enlightened  
24 management and their further developments should be  
25 encouraged. It is desirable that there should eventually  
26 be some comprehensive provision for occupational health  
27 covering work phases of all kinds - both large and small.  
28 It is also urged that the governments at Federal and  
29 Provincial levels should set the pattern by organizing  
30 complete occupational health services covering their  
various establishments.

Finally, sir, this material is





13c. The Association feels that it is imperative that local mental health services be extended immediately to all areas in the province to assist and augment the work of the public health nurses, the health unit directors, and the physicians in private practice. These services should be directed primarily towards the prevention of mental illness in all its phases.

13d. The Association wishes to commend the present trend in British Columbia to provide more nursing services to the majority of our people. We hope that the Commission lend its support to this trend so as to have it furthered as quickly as possible and that it be augmented by the provision of more nurses in all areas, as well as Homekeepers' Services in those areas showing a need therefor. These services should be followed as soon as possible by the provision of rehabilitation personnel such as physiotherapists, occupational therapists, speech therapists, and recreational therapists in sufficient numbers to serve the needs of the community.

13e. Good occupational health services are now regarded as a normal function of enlightened management and their further development should be encouraged. It is desirable that there should eventually be some comprehensive provision for occupational health covering work phases of all kinds - both large and small. It is also urged that the Governments at Federal and Provincial levels should set the pattern by organizing complete occupational health services covering their



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2  
3 respectfully submitted in the hope that it may be of some  
4 benefit to the Commission in its deliberations on health  
5 services.

6 May I draw to your attention that we  
7 openly and very blatantly enlarge upon and support the  
8 dental presentation and secondly, on page 15, Section 44,  
9 dealing with the possibility of a national sanitary code.

10 THE CHAIRMAN: Thank you very much,  
11 Mr. Geekie. Is there anyone associated with you who  
12 may wish to make a statement further expanding any part  
13 of the brief that you haven't read to which you just  
alluded?

14 MR. GEEKIE: I think not. We will be  
15 open to any questions you may have.

16 THE CHAIRMAN: You run the risk there  
17 may be no questions. Dr. Baltzan?

18 COMMISSIONER BALTZAN: Ladies and  
19 gentlemen, I appreciate very much your brief. I apolo-  
20 gize. I came here prepared for another brief. I haven't  
21 fully studied your brief. If I don't ask you questions  
it is because I haven't gone through it by error.

22 THE CHAIRMAN: Miss Girard?

23 COMMISSIONER GIRARD: Mr. Chairman,  
24 Mr. Geekie: I wonder if one of the nurses, perhaps Miss  
25 Hunter, could answer: in paragraph 8, Section A, it says:

26 "The Association would thus like to  
27 recommend that the Schools of Public  
28 Health, Schools of Nursing, etc., be  
29 encouraged to give further considera-  
30 tion to the possibility of more joint



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THE CHAIRMAN: Thank you very much. Mr. Geekie. Is there anyone associated with you who may wish to make a statement further expanding any part of the brief that you haven't read to which you just alluded?

MR. GEERIE: I think not. We will be open to any questions you may have.

THE CHAIRMAN: You ran the risk there may be no questions. Mr. Baltzany.

COMMISSIONER BALTZANY: Ladies and gentlemen, I appreciate very much your brief. I apologize. I came here prepared for another brief. I haven't fully studied your brief. If I don't ask you questions it is because I haven't gone through it by error.

THE CHAIRMAN: Miss Girard?

Mr. Geekie: I wonder if one of the nurses, perhaps Miss Hunter, could answer: in paragraph 8, Section A, it says "The Association would thus like to recommend that the Schools of Public Health, Schools of Nursing, etc., be encouraged to give further consideration to the possibility of more joint





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training of the various disciplines  
engaged in the 'Public Health Team'".

Is there a concrete plan or is there  
any program that you can tell us about whereby there  
could be more joint training of public health nurses  
and other workers in the public health field since this  
is recommended?

MISS HUNTER: I don't think that we  
have such a plan really operating in Canadian public  
health schools, schools of public health. The School  
of Hygiene in Toronto has some. I think what we would  
like to see would be, if possible, all the people that  
are represented here in this kind of public health, get  
some of their courses together, some of their thinking  
should follow along the same lines.

There must be some chance for joint  
training. I don't think we have any particular plan.  
We hope there is something developing at our University  
here in the medical program.

COMMISSIONER GIRARD: You mean at the  
present time, every person taking some course in the  
University in some branch or other of public health,  
are not taking any of these in common; none of these  
courses are in common for public health doctors and  
public health nurses? There are some courses together?

MISS HUNTER: That is not so here.

COMMISSIONER GIRARD: That is what  
you wish to have?

MISS HUNTER: Yes.

MR. GEEKIE: In the University of



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training of the various disciplines engaged in the "Public Health Team". Is there a concrete plan or is there any program that you can tell us about whereby there could be more joint training of public health nurses and other workers in the public health field since this is recommended?

MISS HURON: I don't think that we have such a plan really operating in Canadian public health schools, schools of public health. The School of Hygiene in Toronto has some. I think what we would like to see would be, if possible, all the people that are represented here in this kind of public health, get some of their courses together, some of their thinking should follow along the same lines.

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COMMISSIONER GILKIN: That is what

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MR. GEEKE: In the University of



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4 Toronto School of Hygiene you have physicians, dentists,  
5 veterinarians, training in their public health just two  
6 blocks from the School of Nursing, where the nurses are  
7 taking post-graduate training in public health.

8                   Never do these two groups meet each  
9 other, let alone take any training together. We feel  
10 it is a definite disadvantage to the personnel working  
11 together jointly as a team when they are on the field.

12                   COMMISSIONER McCUTCHEON: You mean they  
13 don't meet in the classroom?

14                   MR. GEEKIE: A point well taken. I  
15 think there is very little otherwise. We might add to  
16 this, there are some public health personnel, the so-  
17 called smaller group, of which I happen to be one, who  
18 were primarily trained in the United States, which is  
19 very difficult in that you are not only divorced from  
20 your fellows, but divorced from the same basic training  
21 your colleagues are receiving.

22                   COMMISSIONER GIRARD: May I say at the  
23 University of Montreal at the School of Hygiene the  
24 nurses, doctors, sanitary engineers, sanitary inspectors,  
25 have some courses together, courses that are related to  
26 all of them; various disciplines in the School of Hygiene.

27                   On page 4 you say the Association wishes  
28 to commend the present trend in British Columbia to  
29 provide home nursing services to the majority of our  
30 people. I have heard in another brief, and I think I  
31 heard yesterday also, that public health nurses are  
32 doing bedside care in a number of areas in this province.

33                   This was very good because I think we





Toronto School of Hygiene you have physicians, dentists, veterinarians, training in their public health just two blocks from the School of Nursing, where the nurses are taking post-graduate training in public health.

Never do these two groups meet each other, let alone take any training together. We feel it is a definite disadvantage to the personnel working together jointly as a team when they are in the field. DONALDSON: Now, when they don't meet in the classroom?

think there is very little otherwise. We might add to this, there are some public health personnel, the so-called smaller group, of which I happen to be one, who were primarily trained in the United States, which is very difficult in that you are not only divorced from your fellows, but divorced from the same basic training your colleagues are receiving.

DONALDSON: Now I say at the University of Montreal at the School of Hygiene the nurses, doctors, sanitary engineers, sanitary inspectors, have some courses together, courses that are related to all of them; various disciplines in the School of Hygiene. On page 1 you say the Association wishes

to commend the present trend in British Columbia to provide home nursing services to the majority of our people. I have heard on another level, and I think I heard yesterday also, that public health nurses are doing bedside care in a number of areas in this province. This was very good because I think we



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3 have been trying to get public health nurses to give  
4 bedside care, more generalized program. My thinking  
5 relating to this was, due to the fact that a number of  
6 briefs are advocating home care plans, if there were any  
7 community-based home care plans started in this province  
8 would the public health nurses be able to carry on?

9 I know we always look to the Victorian  
10 Order of Nurses, a voluntary agency, to do some of this.  
11 Since you are doing bedside nursing, can the public health  
12 nurses in this province take on the home care plans if  
13 they were community-based or hospital-based or agency-  
based?

14 MISS HUNTER: It would require an  
15 expansion of the service because if you add you would  
16 need more staff, but I believe as an organization we are  
17 capable of doing it if we had additional staff.

18 COMMISSIONER GIRARD: They are already  
19 doing it. This is one, the only province where public  
20 health nurses are doing it, so they would be the logical  
21 persons who would be almost ready - this is my question,  
22 almost ready to take on home care plans because your  
public health nurses are already doing some bedside care.

23 MISS HUNTER: That is true. In many  
24 centres throughout the province they are doing it.

25 COMMISSIONER GIRARD: I see you also  
26 advocate home care plans here.

27 MISS HUNTER: Yes.

28 COMMISSIONER GIRARD: So you would  
29 feel all you would have to do would be to get some home-  
30 makers, physiotherapists, on the staff?



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COMMISSIONER GIRARD: So you would feel all you would have to do would be to get some home-makers, physiotherapists, on the staff?





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3 MISS HUNTER: I believe so.

4 COMMISSIONER GIRARD: Has the Public  
5 Health Department any home care plans?

6 MR. GEEKIE: Could I refer this to  
7 Dr. Mackenzie?

8 DR. MACKENZIE: Yes, they have. The  
9 method by which this is brought about, is being brought  
10 about, by stimulation, not so much with the Provincial  
11 Department of Public Health, but through the health units  
12 who are attempting on the local level to find suitable  
13 women to work out the mechanism whereby this could be  
14 carried out and is carried out in at least three communi-  
ties.

15 COMMISSIONER GIRARD: Are your health  
16 units under the Department of Health?

17 DR. MACKENZIE: A little bit of both,  
18 under their own local boards, but there is a very close  
19 liaison with the Provincial Department outside of metro-  
politan areas, very, very close working with the province.

2 20 COMMISSIONER GIRARD: There are no  
21 further questions from me, Mr. Chairman, because I don't  
22 see Dr. Stewart Murray here and I miss him.

23 THE CHAIRMAN: Public health districts;  
24 how do they come into being?

25 DR. MACKENZIE: They are by and with,  
26 it is historical, by and with the advice - the area, by  
27 the administrative - the elected representative within  
28 your area of the municipality and the school board will  
29 meet together and form a unit board that becomes the  
30 health unit.



Health Department any home care plans?

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method by which this is brought about, is being brought

about, by estimation, not so much with the Provincial

who are attempting on the local level to find suitable

women to work out the mechanism whereby this could be

carried out and is carried out in at least three commu-

ties.

write under the Department of Health.

DR. MACKENZIE: A little bit of both.

water their own local boards, but there is a very close

collaboration very, very close working with the province.

COMMUNITY HEALTH SERVICES: There are no

further questions from me, Mr. Chairman, because I don't

see Dr. Stewart Murray here and I miss him.

MR. CHAIRMAN: Public health districts;

how do they come into being?

it is historical, by and with the advice - the area, by

the administrative - the elected representative within

your area of the municipality and the school board will

meet together and form a unit board that becomes the

health unit.



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3 THE CHAIRMAN: You devoted a substantial  
4 section of this brief to an expansion of the dental  
5 brief, but independently, and there was considerable  
6 stress laid upon the fluoridation situation. Have you  
7 any suggestions to put forward that might take care of  
8 what appears to be the situation here of an impasse  
9 having come about in which not much progress is being  
10 made towards fluoridation?

11 Your figures, overall figures, provin-  
12 cially percentage-wise, the population, is far below the  
13 figures that we have heard in any other province in  
14 Canada, and this is the eighth province we have been in.

15 MR. GEEKIE: Dr. Yeo?

16 THE CHAIRMAN: Is there anything parti-  
17 cular to British Columbia that has singled it out to the  
18 extent of this lack of fluoridation? In Alberta I think  
19 the figures we got were close to 50%.

20 DR. YEO: I think there are two basic  
21 reasons; one that I spoke to in the dental brief was  
22 that we seem to have a greater vocalization from the  
23 anti-fluoridationists than we do from the fluoridation  
24 proponents.

25 THE CHAIRMAN: They operate in the  
26 other provinces. We hear the same explanation; you were  
27 going to grow horns and do everything else if fluorida-  
28 tion was adopted. We find large cities in great areas  
29 in these provinces accepting fluoridation even in terms  
30 of 66 and two-thirds percent.

Is there anything peculiar to British  
Columbia in that respect?





THE CHAIRMAN: I am devoted a substantial

section of this brief to an expansion of the dental  
field, but incidentally, and there was considerable  
stress laid upon the fluoridation situation. Have you  
any suggestions to put forward that might take care of  
what appears to be the situation here of an impasse  
having come about in which not much progress is being  
made towards fluoridation?

MR. GREGG: Yes, I think the population, is far below the  
figures that we have heard in any other province in  
Canada, and this is the eighth province we have been in.

MR. GREGG: Yes, I think there are two basic  
reasons for this lack of fluoridation? In Alberta I think  
the biggest one was cost of it.

MR. GREGG: I think there are two basic  
reasons, one that I spoke to in the dental brief was  
that we seem to have a greater opposition from the  
anti-fluoridationists than we do from the fluoridation  
proponents.

THE CHAIRMAN: They operate in the  
other provinces. We hear the same explanation; you were  
going to grow norms and do everything else in fluoridation.  
The one question we have is that the cost of it is too high  
or is it two-thirds correct.

Is there anything peculiar to British  
Columbia in that respect?



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4 DR. YEO: I think one peculiar fact  
5 is that we have more people voting against it, there  
6 seem to be more anti-fluoridationists here than in any  
other province.

7 THE CHAIRMAN: Can you tell me why?

8 DR. MACKENZIE: Could I add - we have  
9 never had a clear cut statement from the Provincial  
10 Government being in favour of this particular measure.  
11 Our Provincial Department has not made such a statement.

12 COMMISSIONER VAN WART: Has your  
13 Provincial Minister of Health made any statement as to  
his attitude?

14 DR. MACKENZIE: Not to my knowledge,  
15 sir. He hasn't mentioned it to me.

16 MR. GEEKIE: This is, in a very large  
17 way, rather directly related to recommendations that we  
18 made regarding education and it is most certainly, in  
19 this area - I have heard views by many, including the  
20 Dental Association, this poor showing regarding fluorida-  
21 tion, has, in fact, been the result of a very poor educa-  
22 tional program with the general public regarding fluorida-  
tion, to a very large extent in issues of this type.

0/dpw 23 This, to a very great degree, depends  
24 on the mass education program that you are able to  
25 conduct in the area. This is one area, and I think this  
26 is not only true in British Columbia, but all across the  
27 nation, in which we have the very finest support from  
28 most parts, and mass health programs for mass media  
29 outlined in all other facets concerned with this but  
30 have, in effect, done an extremely poor job ourselves







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4 in being able to present our materials to them, and  
5 this, I think, is the result of very poor research into  
6 actions we have taken as such by the people concerned  
7 with it in the country as a whole.

8 THE CHAIRMAN: Have you any naturally-  
9 fluoridated areas -- areas in which the water, the  
10 fluoride content of the water comes up to the standard,  
11 such as are to be found in other provinces?

12 DR. YEO: We have one small village  
13 which has about one-half the recommended concentration.  
14 That is the only place in British Columbia.

15 THE CHAIRMAN: Has there been any  
16 investigation made by a Committee of the Legislature  
17 or something of that kind?

18 DR. YEO: No, sir.

19 DR. SMITH: Mr. Chairman, they had the  
20 same problem in the installation of chlorination years  
21 ago. I think what brought it about was during the war  
22 when the American Navy would not take the water unless  
23 it was chlorinated, and it had to be brought through by  
24 legislation.

25 COMMISSIONER STRACHAN: Would it be fair  
26 to ask this group if they have any opinion regarding too  
27 much activity by the dental profession? We have part of  
28 our society that live on doubt and suspicion, and I know  
29 it is a fact that there are certain people in our society  
30 who cannot see why dentists should be in favour of fluori-  
dation without some ulterior motive, and they are still  
trying to figure out what that ulterior motive is.

THE CHAIRMAN: They all want to go on

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which has about one-half the recommended concentration.  
That is the only place in British Columbia

THE CHAIRMAN: Has there been any

investigation made by a Committee of the Legislature  
on something of that kind?

DR. YEO: No, sir.

THE CHAIRMAN: Mr. Chairman, they had the

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when the American Navy would not take the water unless  
it was chlorinated and it had to be brought through by

CHAIRMAN: STANBURN: Would it be fair

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one society that live in doubt and suspicion, and I know  
it is a fact that there are certain people in our society  
who cannot see why dentists should be in favour of fluorid-

ication without some ulterior motive, and they are still  
trying to figure out what that ulterior motive is.

THE CHAIRMAN: They all want to go on



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3 holiday.

4 COMMISSIONER STRACHAN: I think this  
5 is factual.

6 MR. GEEKIE: I would offer the opinion  
7 that this may, in part, be due to the fact that the  
8 fluoridation issue, as such, and mass education, has  
9 been carried almost exclusively by the dental profession  
10 itself, and it has not received the degree of support by  
11 the other professions that are definitely involved.

12 The medical profession, for one, is  
13 most definitely involved because of the issues at stake.  
14 I think, in large part, this may be a very definite  
15 factor, and this is being promoted and put forward always  
16 predominantly by the same group. And when it does not  
17 receive the same degree of support by groupings surroun-  
18 ding it in the medical profession, it tends to produce  
19 this sort of thing.

20 COMMISSIONER VAN WART: Would not lay  
21 organizations who are going to benefit the most from  
22 fluoridation co-operate?

23 MR. GEEKIE: The first recommendation  
24 of a Federal-Provincial Government for formation of a  
25 national health agency was thinking in terms of a counter-  
26 part citizens' organization who would be primarily  
27 concerned with dental decay and particularly in terms of  
28 fluoridation and public education in regard to it.

29 COMMISSIONER VAN WART: Unless they  
30 do, it is natural to assume they could not care less  
what the dental bill is going to be.

THE CHAIRMAN: Going back to your idea







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4 of governmental support for the formation of an organiza-  
5 tion, do you see that as a government function rather  
6 than as a function of the local society, the local  
7 groupings?

8 MR. GEEKIE: I think it is predominantly  
9 the citizens themselves -- that is where the problem  
10 lies. But most certainly, support from the governmental  
11 agencies would be a very definite asset and certainly  
12 would not be without a precedent. It has been done  
13 several times before in voluntary health agencies in  
14 the country.

15 THE CHAIRMAN: What do you mean by that?  
16 I was visualizing Ottawa or Victoria sending someone up  
17 to drum up support for an organization.

18 MR. GEEKIE: In the early stages, for  
19 example, of the Canadian Tuberculosis Association, it  
20 was, to some degree, sponsored and supported by the  
21 Federal Government until such time as it was able to get  
22 started and finance itself. It is not strictly financial.  
23 It is extremely difficult for a voluntary health agency,  
24 in its early stages, to fly in the face of financial  
25 official doctination.

26 THE CHAIRMAN: Have you in mind that  
27 money might be made available for a pilot project or  
28 something of that kind?

29 MR. GEEKIE: Yes, sir.

30 THE CHAIRMAN: Any other questions or  
observations?

Now, while you are still here, is there  
any other phase of your work that has not been specifically







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2  
3 referred to that you would like to make reference to?

4 MR. WEBB: I would like to elaborate  
5 on our sanitary inspectors' proposal of a sanitary code.

6 THE CHAIRMAN: Yes.

7 MR. WEBB: We indicate in the brief  
8 that it would be for a standardizing legislation or a  
9 standard reference for councils and all levels of govern-  
10 ment legislation, but we feel that there is also another  
11 aspect, and that would be directed toward industry. We  
12 feel there is a public need today.

13 From my own experience, I find equip-  
14 ment coming on the market where the thought of sanitation  
15 has somehow been dropped.

16 THE CHAIRMAN: What kind of equipment  
17 have you in mind?

18 MR. WEBB: I have four instances in  
19 the last year. One of our newest bowling alleys put in  
20 very up-to-date equipment made by a name brand, and he  
21 used to be very proud of his sanitation -- that he changed  
22 his hand towels after every game.

23 When I went to see him, he told me,  
24 "I have got rid of that hand towel; I have something  
25 better yet". And he showed me a scoreboard where there  
26 is a black ball suspended in a container where it is a  
27 hand moistener for all the bowlers, and then an electric  
28 hot-air hand drier.

29 He held this as being the optimum in  
30 sanitation, and I said, "Well, I feel that is a public  
finger bowl, and in these days of enteric infections  
it represents a very good opportunity to transfer





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3 diseases of that nature".

4 I have asked him to put disinfectant  
5 in it. I checked back with him after some time and he  
6 had experienced difficulty with the janitors in servicing  
7 it, and the people didn't like the smell of chlorine.  
8 I had to offer him some different disinfectant, odorless  
9 type and perfumed, and so on.

10 We were faced with the problem that  
11 we had to improvise to take care of a manufacturer's  
12 shortcomings.

13 In a hospital, I discovered plastic  
14 carafes on the bedside tables that cannot be washed in  
15 the hot water dishwasher. They are rough in surface  
16 so they won't fall from the patients' hands, and they  
17 collect dirt and therefore invite contamination.

18 I found an institution where plastic  
19 eyedroppers were being used for medication of patients  
20 because the glass ones had broken, or had worn out, and  
21 the plastic ones were thought to be more durable. But,  
22 when the nurse at the time suggested that with the  
23 children the eye infections seemed to be getting worse  
24 rather than better, and on taking these eyedroppers  
25 apart, we found that the chlorohexadrene 200 was quite  
26 evident in the bulb. In other words, trying to do cold  
27 sterilization with plastic eyedroppers.

28 There is the ultra-violet in use in  
29 barber shops, and it is held as good for certain viruses,  
30 but we know the limitations of ultra-violet are that they  
won't penetrate any obstructing film or article, and does  
not do the underside of articles.







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4 We cautioned the barbers on it, on  
5 their sole reliance on sterilizers. We say if a thing  
6 is put in a cabinet clean, it will come out clean, but  
7 we won't say it is doing the job. Barbers are relying  
8 on that because it is sold as a sterilizer

9 In swimming pools, the objection to  
10 chlorine has been rather impressed upon them by companies  
11 putting out ultra-violet water sterilizers which consist  
12 of shining ultra-violet rays on shallow water at the  
13 point of entry to the pool.

14 Although we feel it is a good thing in  
15 that it may control viruses that chlorine won't, it  
16 does not provide inter-bather sterilizing in the pool,  
17 and therefore is suitable only as an adjunct but not as  
18 a substitute for the present swimming pool water steriliza-  
19 tion.

20 And, then, in the plumbing codes, we  
21 notice certain reductions in hand washing fixtures at  
22 the time when our hepatitis rate is about six times the  
23 normal.

24 We visualize, then, that information  
25 of a form of sanitary code should be made available to  
26 industry and go so far so that they do not have to learn  
27 by trial and error, and in industry, too.

28 THE CHAIRMAN: Who should do that?

29 MR. WEBB: We feel that because industry  
30 is largely involved, it might very likely be a project  
put to some philanthropic industrialist because the  
information is always ready at hand in the findings of  
the National Sanitation Foundation of Ann Arbor, Michigan,







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2  
3 who have twelve clinics and made quite an extensive  
4 study of all these phases of sanitation.

5 THE CHAIRMAN: For instance, like the  
6 National Building Code that was evolved and issued by  
7 the National Research Council; was it not?

8 MR. WEBB: That is true.

9 THE CHAIRMAN: Do these things belong  
10 in that type of code?

11 MR. WEBB: We feel that the National  
12 Sanitation Foundation's findings, of which I have here  
13 a book -- unfortunately, it is quite old, 1948 vintage,  
14 but the facts still apply. We feel that those could be  
15 segregated into two types: one, regulatory standards and  
16 the other, equipment standards and possibly industry  
17 could be induced to support one part of it, and the  
18 Government, under the National Research Council and the  
19 Central Mortgage and Housing Corporation, possibly the  
20 legislative part of it.

21 THE CHAIRMAN: Into another field  
22 related, it is the question of water pollution. Does  
23 that come within the sphere of the work of the public  
24 health officers?

25 MR. WEBB: It comes within the sphere  
26 of the sanitary engineer who is on the Board of the  
27 Pollution Control or Secretary of the Pollution Control  
28 Board in this province.

29 THE CHAIRMAN: And what is your view?  
30 I mean, are you satisfied with what is being done to  
prevent water pollution; the pollution of streams?

MR. WEBB: We feel that the time is not

who have twelve clinics and make quite an extensive study of all these phases of sanitation.

THE CHAIRMAN: For instance, into the National Building Code that was evolved and issued by the National Research Council; was it not?

MR. WEBB: That is true.

In that type of code?

MR. WEBB: We talk about the national Sanitation Foundation's findings, of which I have here a book -- unfortunately, it is quite old, from 1934, but the facts still apply. We feel that these could be segregated into two types: one, regulatory standards and the other, solid and standards and possibly industry could be induced to support one kind of it, and the Government, under the National Research Council and the Central Mortgage and Housing Corporation, possibly the legislative type of it.

THE CHAIRMAN: Into another field?

MR. WEBB: It is the question of water pollution. I am not sure that it is the sphere of the public health officials.

MR. WEBB: It comes within the sphere of the sanitary engineer who is on the board of the Pollution Control or Secretary of the Pollution Control board in this province.

THE CHAIRMAN: And that is your view?

MR. WEBB: I mean, are you satisfied with what is being done to prevent water pollution; the pollution of streams?

MR. WEBB: We feel that the time is not



1 ROYAL COMMISSION  
2 ON  
3 too soon, but we are not too late either. Our streams  
4 are still in fair shape and can be improved upon and they are  
5 not beyond the point of no return.

6 We are very encouraged by the steps  
7 that have been taken so far.

8 THE CHAIRMAN: Is there anything else  
9 that should be developed? If not, we want to thank you  
10 very much for the preparation of this document which  
11 shows that a great deal of care was exercised in compiling  
12 it, and in putting it in a readable form and it will be  
13 of much help to us. Thank you very much.

14 We will now recess until 9 o'clock  
15 tomorrow morning.

16 --- Adjournment.  
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# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

VANCOUVER

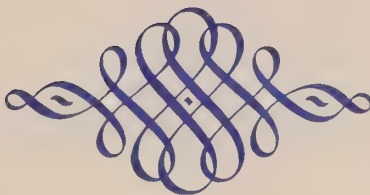
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Vancouver, British  
Columbia, on the 21st day of  
February, 1962.

COMMISSIONER MEMBERS:

CHIEF JUSTICE EMMETT M. HALL ----- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE







SUBMISSIONS

Submission of the City of Vancouver	6178
Submission of the Health Officers of British Columbia	6189
Submission of the College of Physicians and Surgeons of British Columbia	6222
Submission of the British Columbia Old Age Pensioners Organization	6340
Submission of the Canadian Arthritis and Rheumatism Society, British Columbia Division	6244
Submission of the Family Service Agency of Greater Vancouver	6271
Submission of the Vancouver Branch of the National Health Federation	6283
Submission of the Pharmaceutical Associa- tion of the Province of British Columbia	6290
Submission of the British Columbia Hospitals Association	6333
Submission of the Vancouver General Hospital	6353
Submission of the Young Women's Christian Association of Vancouver	6362







Vancouver, B.C. 6178  
Wednesday,  
February 21, 1962.

--- On resuming at 9.00 o'clock a.m.

THE CHAIRMAN: We are now ready to  
proceed with item 5A on the order of appearances, the  
City of Vancouver brief.

THE SECRETARY: Mr. Chairman, before  
Dr. Gayton starts off I would like to file with the  
Commission exhibit 150B which is a study of pre-paid  
medical coverage in British Columbia, 1961, filed by the  
Canadian Medical Association.

--- EXHIBIT NO. 150B: Study of pre-paid medical  
coverage in British  
Columbia, 1961.

THE SECRETARY: The brief now being  
presented will be exhibit 154.

--- EXHIBIT NO. 154: Submission of the City  
of Vancouver.

SUBMISSION

of the

CITY OF VANCOUVER.

APPEARANCES:

DR. J. L. GAYTON

COMMISSIONER GERALD SUTTON BROWN.



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Study of pre-paid medical  
coverage in British  
Columbia, 1961.

THE SECRETARY: The brief now being

presented will be exhibit 15A.

Submission of the City  
of Vancouver.

of the

CITY OF VANCOUVER.

APPEARS:

DR. J. L. GAYTON





1 DR. GAYTON: Mr. Chairman, ladies and  
2 gentlemen, I am Dr. Gayton, the City Health Officer of  
3 Vancouver and also Senior Medical Officer for the  
4 Metropolitan Board of Health. With me this morning is  
5 Commissioner Gerald Sutton Brown of the Board of Adminis-  
6 tration of the City of Vancouver.

7 I wish to thank you for allowing me to  
8 appear first this morning because the Board of Health is  
9 meeting at ten o'clock.

10 1. The following brief is submitted under  
11 heading of the first paragraph of the Order-in-Council  
12 P.C. 1961-883 which reads in part, - "The Commission has  
13 been asked to inquire into and report upon the existing  
14 facilities and the future need for health services for  
15 the people of Canada and the resources to provide such  
16 services and to recommend such measures, consistent with  
17 the constitutional division of legislative powers in  
18 Canada, as the Commissioners believe will ensure that the  
19 best possible health care is available to all Canadians."

20 Recommendations:

21 2. THAT the Commission study the present  
22 sharing of responsibility and distribution of costs  
23 between the three levels of government in regard to local  
24 public health services and hospital capital expenditures,  
25 with a view to producing a formula that will define the  
26 responsibilities of each in relation to the taxation  
27 sources available to raise the necessary funds.

28 3. The British North American Act which  
29 defines the relative authority of federal and provincial  
30 governments is very vague in its delegation of authority

GAYTON

519

DR. GAYTON: Mr. Chairman, ladies and

Gentlemen, I am Dr. Gayton, the City Health Officer of

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sharing of responsibility and distribution of costs

between the three levels of government in regard to local

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The British North American Act which

defines the relative authority of federal and provincial

governments is very vague in its delegation of authority





1 in the field of health, aside from a few specific items.  
2 But it has been stated that "most constitutional  
3 authorities included health among the residual powers  
4 generally accepted as provincial responsibilities under  
5 interpretations of the property and civil rights' clause  
6 of the act."

7 (The Administration of Public Health In  
8 Canada, Dept. of National Health & Welfare, Ottawa,  
9 January, 1958.)

10 4. Lack of clean-cut division of respon-  
11 sibility between the National, Provincial and Local levels  
12 of government still persists. Over the years, however,  
13 many fields of responsibility have been either accepted  
14 or thrust upon local government without benefit of  
15 adequate terms of reference. It is highly desirable and  
16 even essential for proper functioning of local government  
17 that areas of responsibility should be well defined at  
18 all levels so that efficient service and full coverage  
19 can be provided without conflict or overlapping.

20 5. The only significant source of revenue  
21 available to municipalities is the property tax. If, in  
22 providing services to people as individuals, families  
23 and small groups, the greatest efficiency is achieved by  
24 having these services administered by local government,  
25 then the funds for such services should come in large  
26 part from other tax sources collected at the Provincial  
27 and Federal levels and not by arbitrarily determined  
28 grants.

29 6. Because local government is most aware of  
30 the needs of its citizens and the local community





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and small groups, the greatest efficiency is achieved by

having these services administered by local government,

then the funds for such services should come in large

part from other tax sources collected at the Provincial

and Federal levels and not by arbitrarily determined

grants.

Because local government is most aware of

the needs of its citizens and the local community



1 generally, it has no doubt assumed obligations for  
2 providing services that it should not have assumed, or  
3 for which no responsibility had been placed on the local  
4 government. It is important that this Royal Commission  
5 attempt to clarify these fields of responsibility in  
6 keeping with the British North American Act and other  
7 relevant legislation.

8 7. In assigning responsibility for a service  
9 there must be an equal and parallel provision of means  
10 for discharging this obligation. Hence, a review of the  
11 proper division of responsibility between the three levels  
12 of government must also include a study of the ability  
13 to raise funds so that the costs of such service are  
14 shared equitably. The assignment of responsibility for  
15 service, and authority for taxation are inseparable and  
16 should be thoroughly studied by the Commission.

17 8. As examples of confusion and inequity in  
18 this field, we wish to cite two examples.

19 I might mention the first example is  
20 paralleled almost exactly by the submission of the North  
21 Shore Union Board of Health. These submissions were  
22 prepared quite independently and unknown to one another  
23 but they are almost identical in nature.

24 9. A. First Example - Public Health Costs

25 Though the public health services rendered  
26 to citizens in urban and rural areas of the province of  
27 British Columbia are almost identical and the metropolitan  
28 and provincial departments have both shown a sincere  
29 desire to maintain a good quality of service, the ratio  
30 of the division of costs for this service between the



1 Generally, it has no doubt assumed obligations for  
 2 providing services that it should not have assumed, or  
 3 for which no responsibility had been placed on the local  
 4 Government. It is important that this Royal Commission  
 5 attempt to clarify these fields of responsibility in  
 6 keeping with the British North American Act and other  
 7 relevant legislation.  
 8 Y. In assigning responsibility for a service  
 9 there must be an equal and parallel provision of means  
 10 for discharging this obligation. Hence, a review of the  
 11 proper division of responsibility between the three levels  
 12 of Government must also include a study of the ability  
 13 to raise funds so that the costs of such services are  
 14 shared equitably. The assignment of responsibility for  
 15 service, and authority for taxation are inseparable and  
 16 should be thoroughly studied by the Commission.  
 17 8. As examples of confusion and inequity in  
 18 this field, we wish to cite two examples.  
 19 I might mention the first example is  
 20 paralleled almost exactly by the submission of the North  
 21 Shore Union Board of Health. These submissions were  
 22 prepared quite independently and unknown to one another  
 23 but they are almost identical in nature.  
 24 9. First Example - Public Health Costs  
 25 Though the public health services rendered  
 26 to citizens in urban and rural areas of the province of  
 27 British Columbia are almost identical and the metropolitan  
 28 and provincial departments have both shown a sincere  
 29 desire to maintain a good quality of service, the ratio  
 30 of the division of costs for this service between the





1 province and the local areas is in great contrast.

2 I would like to stop here and mention  
3 something which I do not think came out clearly yesterday  
4 that the province outside of the two metropolitan areas  
5 is covered almost one hundred per cent by seventeen  
6 provincial health units. These are called local health  
7 units in name but the staff, transportation, and so on,  
8 are entirely in the hands of the provincial health branch,  
9 so we call them provincial health units in contrast to  
10 the two metropolitan units of which Metropolitan Vancouver  
11 is one and the City of Vancouver is a part.

12 In each case this division of costs has  
13 been established by arbitrary decision of the senior  
14 government.

15 10. In 1960 the gross cost of operating the  
16 Vancouver City Health Department was \$1,515,380 to which  
17 the Provincial Government and Federal Health Grants each  
18 contributed only 7%. By contrast, local health units  
19 provided by the Provincial Government to nearby urban  
20 areas in the lower mainland and to urban areas throughout  
21 the Province, except for Victoria, received approximately  
22 86% of their support from provincial and federal money  
23 and provided only 14% locally.

24 11. Not only is this disparity so obvious,  
25 but the trend is for the City's position to become  
26 steadily worse. In 1952 the local government provided  
27 79% of the health budget while the provincial government  
28 provided 11% and Federal Health Grants 10%. As mentioned  
29 above, the ratios in 1960 were respectively, Vancouver  
30 86%, Provincial 7% and Federal Health Grants 7%.



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16 Vancouver City Health Department was \$1,515,300 to which

17 the Provincial Government and Federal Health Grants each

18 contributed only 7%. By contrast, local health units

19 provided by the Provincial Government to nearby urban

20 areas in the lower mainland and to urban areas throughout

21 the Province, except for Victoria, received approximately

22 60% of their support from provincial and federal money

23 and provided only 1% locally.

24 Not only is this disparity so obvious,

25 but the trend is for the City's position to become

26 steadily worse. In 1952 the local government provided

27 70% of the health budget while the provincial government

28 provided 1% and Federal Health Grants 10%. As mentioned

29 above, the ratios in 1960 were respectively, Vancouver

30 80%, Provincial 7% and Federal Health Grants 1%.





1 In other words, in less than ten years, the share provided  
2 by the senior governments has decreased by one-third  
3 from 21% to 14%.

4 THE CHAIRMAN: Is that a decrease per-  
5 centage-wise or in actual dollars?

6 DR. GAYTON: Percentage-wise. In actual  
7 dollars it would be a slight increase, a slight increase  
8 in the grants provincially and federally, but not in  
9 keeping with the local costs both municipal and school  
10 board.

11 12. B. Second Example - Vancouver General  
12 Hospital Construction and Out-Patient Costs

13 Local municipalities have always been  
14 subject to pressures for hospital capital costs from two  
15 directions:  
16 (a) from its citizens who need adequate services  
17 and  
18 (b) from hospital societies who find it easier  
19 to put pressure on local officials for financial support  
20 than on those more remote. Hence, the siting and size of  
21 hospitals has tended to depend on the enthusiasm of local  
22 citizens and boards rather than on province-wide planning.  
23 In this report, Vancouver City has for many years borne  
24 a heavy share of the cost of construction of the Vancouver  
25 General Hospital amounting to approximately five million  
26 dollars over the past 11 years. At the same time some  
27 large metropolitan municipalities in the Lower Mainland  
28 have done little in the way of hospital construction and  
29 have contributed nothing to the cost of the Vancouver  
30 General Hospital, although approximately 33% of its





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a heavy share of the cost of construction of the Vancouver

General Hospital amounting to approximately five million

dollars over the past 11 years. At the same time some

have contributed nothing to the cost of the Vancouver

General Hospital, although approximately 33% of the



1 patients are from outside the City of Vancouver.

2 13. In connection with the same hospital, the  
3 City has borne half the cost of maintaining the only out-  
4 patient service in the Province, which is available to all  
5 irrespective of place of residence. The B.C. Hospital  
6 Insurance Service contends that, within the present  
7 wording of the Canadian Hospital Insurance and Diagnostic  
8 Services Act it is impractical or impossible for the  
9 Province to enter into a Federal-Provincial agreement  
10 which would have the effect of relieving the City of  
11 most, if not all out-patient costs. It is obvious that  
12 either the terms of the act need restating or that this  
13 unfair burden on the City should be accepted by the  
14 Province. This would be in line with the opinion of the  
15 Union of B.C. Municipalities "That the entire cost of  
16 hospitals (should) be met from Provincial revenue."

17 (A policy Statement of the Union of B.C.  
18 Municipalities adopted at its 55th Annual Convention,  
19 September, 1958.)

20 14. These are but examples of a lack of clarity  
21 in placing responsibility for local health and sickness  
22 services, which make it clear that a complete review is  
23 needed of responsibility for public health services in  
24 relation to ability to pay.

25 THE CHAIRMAN: Thank you very much, Dr.  
26 Gayton.

27 COMMISSIONER VAN WART: Dr. Gayton, the  
28 last statement from the Union of British Columbia  
29 Municipalities that the entire cost of the hospitals  
30 should be met with provincial revenue, that means they

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1 are also in favour of doing away with co-insurance?

2 MR. GAYTON: I cannot tell you. The  
3 answer may be in this publication of what your tax dollar  
4 should properly be doing for you from which I have quoted  
5 that statement. I would doubt if the answer would be yes.

6 THE CHAIRMAN: I imagine we would have  
7 to know a little more the context, I would not assume  
8 from this that they want the Dominion to get out of the  
9 field and not send about twenty-five million dollars.

10 DR. GAYTON: This is only a short  
11 paragraph and I can read it. This is under hospital  
12 services:

13 "This is a federal-provincial service with  
14 the provincial share being financed by  
15 local taxation to which local governments  
16 are thus subject. So far as municipalities  
17 are concerned, there is complete centra-  
18 lization at the provincial level...."

19 Then this recommendation that I quoted,  
20 "the entire capital costs ----"

21 THE CHAIRMAN: You left out the word  
22 "capital".

23 DR. GAYTON: I am sorry.

24 THE CHAIRMAN: That would bring them in  
25 line with virtually the Alberta situation?

26 COMMISSIONER VAN WART: This sentence  
27 before about the out-patients, the capital cost of that.

28 DR. GAYTON: No, that is the operating  
29 costs.

30 COMMISSIONER VAN WART: This statement



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1 would only apply to the capital part of that?

2 DR. GAYTON: Yes, which is the lesser, of  
3 course.

4 MR. SUTTON BROWN: Perhaps it is not  
5 quite clear but the municipalities do not normally  
6 contribute to the operational costs of hospitals in  
7 British Columbia with the one exception of the City of  
8 Vancouver in relation to the out-patients department  
9 your operational costs are not now a burden at all upon  
10 the municipalities, it is only in relation to capital  
11 costs the municipalities now have to bear a substantial  
12 portion of the burden.

13 COMMISSIONER BALTZAN: I have nothing  
14 specific except one; Dr. Gayton, do the other general  
15 hospitals also provide emergency out-patient service?

16 DR. GAYTON: Some of them do, St. Paul's  
17 particularly.

18 COMMISSIONER BALTZAN: Are they in the  
19 same boat as this?

20 DR. GAYTON: No, they are independent  
21 and so far the City has not contributed either to their  
22 capital costs or to their out-patients. Their out-  
23 patients is not organized, it is an incidental extension  
24 of the in-patient services.

25 COMMISSIONER BALTZAN: They are not so  
26 independent as that, they depend upon dollars?

27 DR. GAYTON: Yes, and the usual capital  
28 assistance from the province and provincial and federal  
29 government.

30 THE CHAIRMAN: Dr. Gayton, did I under-





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26 assistance from the province and provincial and federal

27 government.

28 THE CHAIRMAN: Dr. Gayton, did I under-



1 stand you to say that only in Vancouver in respect to  
2 the Vancouver General the municipality may be called upon  
3 to contribute to operating costs?

4 DR. GAYTON: It is the only out-patient  
5 service in the province.

6 THE CHAIRMAN: That is in respect to  
7 out-patients but as to out-patient service only?

8 DR. GAYTON: Only, yes.

9 COMMISSIONER FIRESTONE: On page 2,  
10 paragraph 7, you say:

11 "The assignment of responsibility for  
12 service and authority for taxation are  
13 inseparable and should be thoroughly  
14 studied by the Commission."

15 Do you have in mind that this Commission  
16 should engage in a study of sources of revenue and  
17 measures of taxation at the federal-provincial level?

18 DR. GAYTON: I am sure I could not see  
19 how that may be separated from the study of health services.

20 COMMISSIONER FIRESTONE: We are just  
21 interested to know what your recommendation means, is  
22 that what you are suggesting?

23 DR. GAYTON: Yes, sir.

24 COMMISSIONER FIRESTONE: Thank you.

25 THE CHAIRMAN: Thank you very much, Dr.  
26 Gayton and Commissioner Sutton Brown. The recommendation  
27 as we understand it is a substantial one and undoubtedly  
28 the constitutional aspects in terms of Dominion-  
29 provincial relationships is one that impinges on the  
30 whole matter of health services and the function of the



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as we understand it is a substantial one and undoubtedly the constitutional aspects in terms of Dominion-provincial relationships is one that impinges on the whole matter of health services and the function of the





1 federal government in relation to health services. We  
2 are grateful to you for your submission and for your  
3 suggestions.

4 DR. GAYTON: Thank you, sir.

5 THE CHAIRMAN: We now have the brief of  
6 the Health Officers' Council of British Columbia.

7 THE SECRETARY: That will be exhibit 155.

8  
9 --- EXHIBIT NO. 155: Submission of Health  
10 Officers of British  
11 Columbia.

12 DR. MacKenzie: Mr. Chairman, I had hoped  
13 that Dr. Gayton would be able to present this brief but  
14 he has to leave and he has asked me to carry on and  
15 present it.

16 I would like to amend the title slightly,  
17 the brief is from the Health Officers of British Columbia;  
18 a minor point, but that is the case.

19 In the summary of the brief I would like  
20 to present the first three pages and then the recommen-  
21 dations at the end.

22 The brief is from the Health Officers of  
23 British Columbia which is composed of nineteen physicians  
24 administering the public health service of British  
25 Columbia, the Indians and the general population. They  
26 have special training in this field of medicine and for  
27 the purpose of this brief these physicians will be  
28 referred to as the Health Officers of British Columbia.  
29 The directors of the Metropolitan Health Unit are  
30 represented by Senior Health Officers.



2 and grateful to you for your submission and for your  
3 suggestions.

DR. DAYTON: Thank you, sir.

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SUBMISSION

of the

HEALTH OFFICERS OF BRITISH COLUMBIA

APPEARANCES:

DR. C. J. G. MacKENZIE

DR. MacKENZIE: In presenting this brief all the above health officers and their advisers have been encouraged to present their views and the brief has been written expressing these views.

We wish to discuss some matters pertaining to the following terms of reference by the Commission, given in Order-in-Council P.C. 1961-883, specifically paragraph A, B, C, D, E, F, J, and K.

The body of the brief deals in detail with the work carried out by the health units and many of the specialized divisions in the provincial and metropolitan public health services. Discussion is arranged under each of the specific terms of reference of the Royal Commission on Health Services.

We would like to put forward some general observations:

I. (a) Most "health plans" that have been instituted or developed in various countries are not in fact health centred. They are plans to deal with disease.

(b) Many of these plans are concerned largely with financing the facilities necessary for the treatment of disease. They are mainly insurance





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Conclusions:

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(b) Many of these plans are concerned largely with financing the facilities necessary for the treatment of disease. They are mainly insurance



1 programmes.

2 (c) The Health Officers' Council is aware of  
3 the value of insurance protection against the costs  
4 of illness. In general the Council favours such  
5 protection but does not consider it to be a  
6 complete health plan.

7 (d) The Council's chief aim is the promotion  
8 of health. To this end we accept the definition  
9 of health given in the preamble to the  
10 Constitution of the World Health Organization.

11 (e) Health is a state of complete physical,  
12 mental and social well-being and not merely the  
13 absence of disease.

14 (f) The Health Officers' Council of British  
15 Columbia feels that the only way to achieve this  
16 positive state of health is through an active  
17 comprehensive and extensive system of disease  
18 prevention and active health promotion.

19 (g) The prompt, complete and humane treatment  
20 of disease is most desirable but a programme based  
21 solely on this concept will be inefficient and  
22 costly. A successful health plan must have within  
23 it an active disease prevention and health promo-  
24 tion organization. This organization must provide  
25 both primary and secondary Preventive Services.

26 II. (a) Any successful programme of disease treat-  
27 ment, preventive and health promotion must be  
28 available to all the people. It must be available  
29 in every community.

30 (b) In the Province of British Columbia, the



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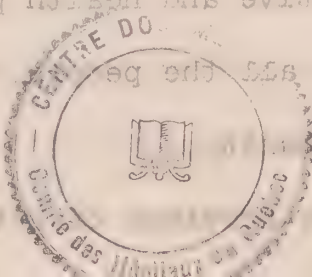
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1 Health Service and Health Units - Provincial and  
2 Metropolitan - have established themselves in the  
3 confidence of the people in every community.

4 (c) Any new or expanded programmes for the  
5 prevention of disease or the active promotion of  
6 health can and should be carried out through the  
7 Health Units.

8 I would now like to refer to the recommen-  
9 dations of the health officers which are at page 38 of  
10 the brief.

11 General recommendations for the future development of  
12 services.

13 1. That all types of health services be  
14 available to all citizens of Canada, irrespective  
15 of geographical location or financial status.

16 2. That prevention of disease and trauma be  
17 made a major part of any health care programme in  
18 Canada.

19 3. In cases where the complete prevention of  
20 disease is still impractical, that provision be  
21 made for the early diagnosis, treatment and re-  
22 habilitation of patients.

23 4. That 2 and 3 above be accomplished by the  
24 expansion of existing facilities and services -  
25 specifically local hospitals and Health Units.  
26 Where local hospitals and Health Units are not in  
27 existence or are inadequate that these institutions  
28 be established or improved at once.

29 5. That a sufficient central organization be  
30 set up and maintained to advise and augment the



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Where local hospitals and Health Units are not in existence or are inadequate that these institutions be established or improved at once.

5. That a sufficient central organization be set up and maintained to advise and suggest the



1 local health services.

2 6. That co-operation between such central  
3 organization and local health services be maintain-  
4 ed at a high level but that the principle that the  
5 central organization exists for the benefit of  
6 local health services and not vice versa be  
7 strictly maintained.

8 7. That insofar as individual regional problems  
9 allow, every effort should be made to maintain  
10 continuity throughout the health services of the  
11 country.

12 8. That when new or expanded services are  
13 organized, they should fit into the existing pattern  
14 of medical practice in Canada. These services  
15 should never interfere with the relationship exist-  
16 ing between the private physician and his patient.  
17 They should, rather, be arranged to augment this  
18 relationship and assist the physician in bringing  
19 services to his patient.

20 9. That substantially more of the national  
21 health dollar should be directed to prevention of  
22 disease and to basic research.

23 Training of Personnel

24 10. That general public health services be  
25 expanded both in scope and in personnel.

26 11. That existing training facilities for  
27 medical, dental, para-medical, and para-dental  
28 personnel be expanded and that new facilities be  
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1 Recommendations for review of laws and regulations, and  
2 cost-sharing.

3 12. That Federal and Provincial laws on public  
4 health, hospitals, medicine, etc. be reviewed,  
5 modernized and, insofar as possible, standarized.

6 13. That regulations for the national control  
7 of urban expansion and the pollution of air, land  
8 and water be set up at all levels of government.  
9 Haphazard growth and growing pollution problems  
10 now affect whole areas and even regions. The  
11 problem has far outstripped municipal control and  
12 in some cases even exceeds Provincial control.  
13 The matter is now of national and even international  
14 importance.

15 14. That such regulations be aimed at preven-  
16 ting the creation of slums and the pollution of  
17 land, air and water rather than abating these  
18 problems when they have occurred.

19 15. That a greater share of the cost of health  
20 services and sanitary works at the local level be  
21 borne by the Federal and Provincial governments.  
22 Laboratory Services.

23 16. That clinical and public health laboratory  
24 services be encouraged to grow to meet growing  
25 needs and that virus laboratories be available in  
26 each Province.

27 Dental Health

28 17. That the fluoridation of public water  
29 supplies becomes general throughout Canada.  
30 Approval of new installations should be made



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each Province.

Public Health

That the fluoridation of public water

supplies become general throughout Canada.

Approval of new installations should be made





contingent on the installation of fluoridation equipment. Present water supplies should be fluoridated upon the decision of responsible government and not by public plebiscite. Where a vote on the matter is allowed, a simple majority should rule.

18. Costs of installing and maintaining fluoridation equipment should be shared by the Federal and Provincial governments and not left solely to local governments.

Industrial Health.

19. General expansion of industrial medical services -- both on the part of the government and industry -- should be encouraged to keep pace with Canada's growing industrial development.

Emergency Medical Services.

20. That emergency medical services be standardized throughout the country and that adequate emergency medical supplies should be stockpiled in each community or main populated areas.

21. That a clear, simple and realistic policy be emphatically stated by all levels of government with respect to emergency, disaster and survival procedures. This policy should be aimed at relieving the confusion and uncertainty at present detectable in the general population. This policy should be standard throughout the country and not contingent on the inaction or apathy (or conversely vigour and interest) of local or Provincial governments.

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Rehabilitation

22. Rehabilitation should be made an integral part of the community health programme.

23. Home nursing, home-maker and home rehabilitation services should be available in all communities.

24. That greater use be made of out-patient facilities at general hospitals and specialized out-patient services be set up (psychiatric, rehabilitation, etc.).

25. That facilities for the care of severely handicapped and mentally defective persons be increased and decentralized and become part of community health services.

26. That the maintenance of a registry of handicapped persons be continued and expanded.

Mental Health.

27. That a vigorous mental health service - both preventive and therapeutic - be set up at the community level in all areas.

28. That the promotion of good mental hygiene be recognized as a basic programme in all public health services.

Radiation Controls.

29. That increased facilities for the study, detection and advice on radiation hazards be established in all regions of Canada and that the facilities of these centres be available to the community health services.

30. That existing laws and regulations regarding



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the industrial use of ionizing radiation from any source be reviewed and extended as necessary, and subsequently be kept under constant review in the light of ever increasing knowledge.

Research.

31. That research - medical and social - into the problems of drug addiction and alcoholism be increased and encouraged with a view to finding a solution to these problems as soon as possible.

32. That research, on all fronts, into the lethal problems of cardiovascular renal disease, carcinoma, and accidents, be expanded and encouraged with a view to preventing or delaying the effects of these diseases.

Physical Facilities.

33. That the present programme for providing community health centres be continued and expanded.

Health Education.

34. That health education in schools and public health services be recognized and promoted as a basic essential to good community health.

THE CHAIRMAN: Thank you, Dr. MacKenzie.

Perhaps, a small point of interest, the Public Health Services of British Columbia, you say the nineteen physicians administer to both the Indian and general population. Is this additional to what is done by the Federal Government in the Indian field?

DR. MacKENZIE: Yes, it is, I wouldn't say it overlaps, but in some areas some health units -- some Indians receive public health services from the local



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1 health unit.

2 THE CHAIRMAN: Is that at the request  
3 of the Indian Department?

4 DR. MacKENZIE: Yes, sir, and further-  
5 more, they pay for it.

6 THE CHAIRMAN: They pay for it. All  
7 right. You can appreciate, Dr. MacKenzie, the list of  
8 recommendations made is comprehensive and indicates a  
9 lot of thought on your part and on the part of those  
10 associated with you in the presentation of this brief.  
11 You will appreciate implementation of them will involve  
12 time and money. I see you have applied yourself to that  
13 in paragraph 173 where you discuss some questions of  
14 priority.

15 In this matter of priority, have you a  
16 view to express as to the adequacy of physicians services  
17 in British Columbia at the present time?

18 DR. MacKENZIE: From my own experience,  
19 sir, the areas are reasonably well covered by physicians.  
20 I am not saying the ratio of physicians to population  
21 is ideal, or even close to ideal in many areas, but in  
22 the remote areas in the province one will find a  
23 physician or more than one physician.

24 THE CHAIRMAN: Are physician services  
25 available generally to the people of British Columbia?

26 DR. MacKENZIE: I think generally  
27 speaking, yes.

28 THE CHAIRMAN: Regardless of the manner  
29 of payment, are people needing services of physicians  
30 receiving those services?

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1 DR. MacKENZIE: I think, in my experience,  
2 sir, yes. I don't think anyone who really needs the  
3 attention of a physician need go without it in this  
4 province.

5 THE CHAIRMAN: You are speaking now of  
6 your experience as a public health officer and from the  
7 information that you have from those associated with you?

8 DR. MacKENZIE: My colleagues, yes.

9 THE CHAIRMAN: So, are we to accept  
10 that in the developing of a health plan in British  
11 Columbia that the priorities that you suggest in paragraph  
12 173 are the ones that you, the ones the public health  
13 officers regard as being the most necessary?

14 DR. MacKENZIE: I think, modifying that  
15 a little bit there with reference to developing preventive  
16 service, both primary and secondary service was considered  
17 to be of priority. The exact amount of priority the  
18 preventive services hold in the over-all picture is a  
19 matter of debate. We think they are of some importance.

20 Obviously there is no better way to deal with the  
21 situation than to remove the problem. We think, with  
22 reference to the preventive services only, these are,  
23 in fact, a reasonable list of the most pressing problems.

24 THE CHAIRMAN: What I mean is this,  
25 that with any given amount of available money at one time,  
26 in one year, would you recommend the use of that money  
27 to pay for physician services or for other health  
28 services in British Columbia?

29 DR. MacKENZIE: That is a very difficult  
30 question. I would think, sir, as things stand at the



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1 moment, that the money should go properly to preventive  
2 services.

3 THE CHAIRMAN: We are really interested  
4 in the opinion of qualified people like yourself who are  
5 the people who see the province as a whole from the fact  
6 that you cover the whole province.

7 On the matter of fluoridation, the  
8 recommendation on page 39, No. 17,

9 "Present water supplies should be  
10 fluoridated upon the decision of respon-  
11 sible government and not by public  
12 plebiscite."

13 What government have you in mind there?

14 DR. MacKENZIE: I am thinking there in  
15 terms of the local government, local council or municipal  
16 board feeling that this is a useful and a necessary thing  
17 in their community.

18 THE CHAIRMAN: On the council's own  
19 responsibility, and it is from the fact that it is a  
20 local responsible government and not by plebiscite.

21 DR. MacKENZIE: That is right, they  
22 could fight the election on this issue rather than have  
23 an individual plebiscite on the issue itself.

24 THE CHAIRMAN: Thank you very much, Dr.  
25 MacKenzie. Miss Girard?

26 COMMISSIONER GIRARD: Yes, Mr. Chairman,  
27 I have one question.

28 On page 17, paragraph 60 reads:

29 "The home nursing service should be an  
30 extension of the present programme carried



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I have one question.

On page 17, paragraph 60 reads:

"The home nursing service should be an

extension of the present program





1 out by the public health nurses and not  
2 left in the hands of private agencies.  
3 In recommending this we do not cast  
4 aspersions on the magnificent work done by  
5 private home nursing agencies. We make  
6 this recommendation because we feel that  
7 the health units can provide this service  
8 at less cost and more efficiently."

9 I think it is a very desirable goal for  
10 public health nurses to do bedside nursing in the homes,  
11 but to the exclusion of voluntary agencies -- I am surprised  
12 that you recommend this. You say, you give cost as one  
13 reason. If I am right the cost of the visits given by  
14 the public health nurses are entirely from tax money and  
15 the cost of the visits given by voluntary agencies, there  
16 is very little tax money. They get a grant, but it is a  
17 very little part of the cost of the visit. So would you  
18 care to explain more, and on efficiency also?

19 DR. MacKENZIE: I don't mean the  
20 standard of nursing efficiency.

21 COMMISSIONER GIRARD: You mean adminis-  
22 trative?

23 DR. MacKENZIE: Administrative efficiency.  
24 Our present policy in the province seems to be where the  
25 voluntary agencies are now carrying out a nursing programme  
26 -- there is no idea of altering this. In the City of  
27 Vancouver or in the City of Victoria, in some of the  
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1 district we feel that there where we already have public  
2 health nurses, we have them in the most remarkable places  
3 in the province, already they have an administrative  
4 programme, they have motor cars, equipment, offices to  
5 work from, and they are having a load, say, five  
6 thousand in rural areas, and in smaller areas their  
7 population down to twenty-five hundred, we seem to be  
8 settling on now, and we feel that in this way we can  
9 carry out an efficient home nursing programme because  
10 it is, normally speaking, the home nursing programme in  
11 an uneconomic area, people are far apart, the roads are  
12 poor, and so on. If the nurse is also carrying on a  
13 general public health programme, this will allow more  
14 efficiency in that situation.

15 We were not here thinking of the cities  
16 of Vancouver, Victoria, Nanaimo and Trail, where the  
17 private nursing agencies are presently at work and where  
18 the population is high enough and close enough together  
19 and whatnot to make this well worthwhile to have an  
20 individual nurse devoting her time entirely to this  
21 particular type of home nursing.

22 COMMISSIONER GIRARD: Would you have  
23 enough qualified public health nurses to do this home  
24 nursing all through the province?

25 DR. MacKENZIE: Yes, we have been doing  
26 it for years in point of fact.

27 COMMISSIONER GIRARD: For some areas?

28 DR. MacKENZIE: In all areas, because  
29 we have been doing it but not getting paid for it. In  
30 the rural areas, nurses have in fact been doing home



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COMMISSIONER GIBSON: Would you have

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1 nursing for much longer than I have been in the service  
2 -- for certainly the last decade. It was needed to be  
3 done and they went ahead and did it.

4 COMMISSIONER GIRARD: When you say home  
5 nursing, do you really mean bedside care?

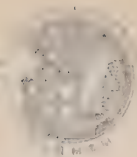
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10 been reduced, and this has become a programme that is  
11 growing so rapidly I would be at a loss to tell you how  
12 much of the province is being covered. A great deal of  
13 it is already being covered now, and we seem to be able  
14 to provide the nurse to do the work.

15 COMMISSIONER McCUTCHEON: Do you mean  
16 the patient is not paying, when you say it is not being  
17 paid for?

18 DR. MacKENZIE: Nobody was paying for it  
19 before.

20 COMMISSIONER McCUTCHEON: The province?

21 DR. MacKENZIE: At the present time,  
22 to get this programme into a community there is a local  
23 assessment of ten cents per person per year. I believe  
24 that that is matched by the senior governments, I think,  
25 roughly speaking to the extent of another twenty cents.  
26 We were doing this service without that particular type  
27 of further remuneration. We were doing it on the regular  
28 service, too, but it was not organized and it was done  
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1 the situation. It is now being put on a regular basis.

2 COMMISSIONER GIRARD: In resume, you  
3 would confine the voluntary agencies to the urban areas?

4 DR. MacKENZIE: They have not been able  
5 to expand past the areas. They have been approached to  
6 do this in the smaller community. They have thought it  
7 over and they have felt it would be ruinous to them to  
8 go much beyond these communities.

9 COMMISSIONER BALTZAN: Dr. MacKenzie,  
10 you brought into focus the item of promotion of physical  
11 fitness. I am pleased to see that. Could the whole  
12 panorama of the medical services be compartmentalized  
13 in something like this: Number one, the promotion of  
14 health, and my question in that respect to what extent  
15 does a physical fitness programme come in?

16 DR. MacKENZIE: In the present programme,  
17 sir?

18 COMMISSIONER BALTZAN: Yes. What is the  
19 contribution?

20 DR. MacKENZIE: I think that the local  
21 health officer and the nurses ----

22 COMMISSIONER BALTZAN: I am thinking  
23 more of the latest thing that has happened about contri-  
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25 DR. MacKENZIE: I think the health  
26 unit's programme is really to promote, urge, suggest and  
27 educate that people do, in fact, take a little more  
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1 much aware of the advantages of a physical health programme  
2 or a physical fitness programme, and starting at the  
3 local level, many of the local agencies, service clubs,  
4 and so on, have for a number of years promoted this and  
5 certainly the role of the health unit here is to urge  
6 and educate along this line.

7 COMMISSIONER BALTZAN: And, then, still  
8 thinking in terms of dividing and compartmentalizing,  
9 in our thinking at least, if not in action, number two  
10 is the feature of preventive medicine, or prevention of  
11 disease, such as the functions on the part of the public  
12 health organizations and the Public Health Departments,  
13 and these have to do with immunization and sanitation.  
14 And that is where the Departments of Health concentrate  
15 upon most?

16 DR. MacKENZIE: That is a part of our  
17 programme, sir.

18 COMMISSIONER BALTZAN: Not the whole  
19 part?

20 DR. MacKENZIE: Not by any means, but it  
21 is certainly the traditional part of our programme.

22 COMMISSIONER BALTZAN: The last thing  
23 as it occurs to me on listening to all these matters,  
24 number three, then, would be diagnostic and therapeutic  
25 measures for the disease element or dis-ease elements  
26 by medical and para-medical groups so that we have ---  
27 and I put it again to make it as clear as my thinking  
28 goes --- that number one element is the promotion of  
29 health; number two is the prevention of disease; and  
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1 dis-ease.

2 DR. MacKENZIE: Yes, sir, and that last  
3 -- I think in that last one the role of the health unit  
4 is a consultant and assisting role rather than a primary  
5 role. In other words, we feel it should definitely be  
6 there to help the physicians dealing with the case to  
7 deal with these cases.

8 COMMISSIONER BALTZAN: I am not going  
9 into details, but do you think that covers ---

10 DR. MacKENZIE: The sequence of the  
11 events we should follow? Yes, I think probably it does.

12 COMMISSIONER BALTZAN: The course of  
13 medicine has been in reverse. The attention has been on  
14 therapeutic, then came in the preventive, and now you  
15 are being to concentrate on how to keep well?

16 DR. MacKENZIE: I think so, sir, but I  
17 think that is a logical development. One has to deal  
18 with the unfortunate problem immediately. This will not  
19 wait. I know until you have dealt with the matter of  
20 disease, and then perhaps with more practical methods of  
21 preventing it, you really have not time nor the ability  
22 to go on with the further promotion. I think we are  
23 reaching the stage now, but I think it has taken many  
24 years to do so.

25 COMMISSIONER BALTZAN: Don't you think  
26 we could have just as much information about the real things  
27 that promote health as we already have about disease?

28 DR. MacKENZIE: I think so, sir.

29 COMMISSIONER VAN WART: Mr. Chairman,  
30 I have a few questions more or less to bring into relief



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COMMISSIONER FAIRMAN: I am not going

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DR. MACKENZIE: The sequence of the

events we should follow? Yes, I think probably it does.

COMMISSIONER FAIRMAN: The course of

medicine has been in reverse. The attention has been on

therapeutic, then came in the preventive, and now you

are being to concentrate on how to keep well?

DR. MACKENZIE: I think so, sir, but I

think that is a logical development. One has to deal

with the unfortunate problem immediately. This will not

wait. I know until you have dealt with the matter of

disease, and then perhaps with more practical methods of

preventing it, you really have not time nor the ability

to go on with the further promotion. I think we are

reaching the stage now, but I think it has taken many

years to do so.

COMMISSIONER FAIRMAN: Don't you think

we could have just as much information about the real things

that promote health as we already have about disease?

DR. MACKENZIE: I think so, sir.

COMMISSIONER VAN WART: Mr. Chairman,

I have a few questions more or less to bring into relief





1 the organization of the health picture in British  
2 Columbia. I wish to congratulate you on a most excellent  
3 brief.

4 DR. MacKENZIE: Thank you, sir.

5 COMMISSIONER VAN WART: The first is  
6 the sixteen health units you speak of. That is synonymous  
7 with the term "provincial health units", is it, and not  
8 in contra-distinction to the metropolitan units?

9 DR. MacKENZIE: Yes.

10 COMMISSIONER VAN WART: Turning to page  
11 5, number 24, you mention each health unit is under the  
12 administrative supervision of a director. The director  
13 is a physician licensed to practice in the Province of  
14 British Columbia.

15 Who appoints that director?

16 DR. MacKENZIE: The provincial government  
17 recruits him. When a suitable candidate is found, his  
18 name is submitted to the Union Board of Health who may  
19 accept or reject him. They nearly always accept him, but  
20 they have the right and power to reject that appointment.

21 COMMISSIONER VAN WART: The Union Board  
22 of Health?

23 DR. MacKENZIE: The Union Board of Health,  
24 yes, sir.

25 COMMISSIONER VAN WART: Is that different  
26 from the Unit Board of Health?

27 DR. MacKENZIE: Well, they are the  
28 Board of Health for the health unit, and are made up of  
29 elected representatives from the municipalities and  
30 school boards within the borders of the health unit.



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school boards within the borders of the health unit.



1 COMMISSIONER VAN WART: You say elected.

2 Elected by vote?

3 DR. MacKENZIE: Yes. It would be  
4 councilors or school board members who had been elected  
5 to, let us say, an alderman of a city. Each city would  
6 send one of its aldermen to the Union Board.

7 COMMISSIONER VAN WART: And the school  
8 board?

9 DR. MacKENZIE: Would send one of its  
10 representatives.

11 COMMISSIONER VAN WART: And they compose  
12 the ----?

13 DR. MacKENZIE: They make up the Union  
14 Board.

15 COMMISSIONER VAN WART: They make up  
16 the Union Board and they administer the medical health  
17 units through the medical director?

18 DR. MacKENZIE: Yes.

19 COMMISSIONER VAN WART: The medical  
20 director then, is appointed by a local unit at the  
21 suggestion of the provincial government?

22 DR. MacKENZIE: Right.

23 COMMISSIONER VAN WART: And if he is  
24 not satisfactory, they can reject him?

25 DR. MacKENZIE: Yes.

26 COMMISSIONER VAN WART: Yes, I understand.

27 Well, carrying on a little further, on  
28 page 14, number 48, that is section 48, you state in the  
29 second sentence:

30 "The health branch and its divisions do





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Well, carrying on a little further, on

page 14, number 44, that is section 18, you state in the

the health branch and its divisions to



1 not exercise direct control over any of  
2 the field organizations, but the closest  
3 co-operation and cordiality exists between  
4 this central office and the field."

5 And, also turning to page 38, section 6:

6 "That co-operation between such central  
7 organization local health services be  
8 maintained at a high level, but the  
9 principle that the central organization  
10 exists for the benefit of the local health  
11 organization and not vice versa be strictly  
12 maintained."

13 DR. MacKENZIE: Yes, sir.

14 COMMISSIONER VAN WART: That is, the  
15 local health unit; the power is in the local health unit  
16 and not in the provincial government?

17 DR. MacKENZIE: That, I think, is what  
18 we have in mind. There are obviously certain areas where  
19 the provincial government does and must have jurisdiction.  
20 Certainly a minor, perhaps, part of the health officers'  
21 duties are the administration of laws.

22 COMMISSIONER VAN WART: That is what I  
23 mean. The government can make laws?

24 DR. MacKENZIE: Yes.

25 COMMISSIONER VAN WART: And you must  
26 carry those laws out?

27 DR. MacKENZIE: Yes.

28 COMMISSIONER VAN WART: But as to  
29 regulations and one thing and another, the final analysis  
30 rests with the local health unit?



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1 DR. MacKENZIE: I think professional  
2 decisions should, yes. The laws are laws that whatever  
3 we are in we must adhere to them, but I think what we  
4 have in mind here is that the local health unit knows  
5 its own area and problems, and they do vary regionally,  
6 and that within our terms of reference as to how situations  
7 will be handled that the local professional decision  
8 be made locally, by either the local nurse, health officer  
9 or certainly the Union Board is probably in as good a  
10 position to know what its needs are in a certain  
11 community.

12 COMMISSIONER VAN WART: This is a method  
13 by which it lessens the control of the higher authority  
14 over the administration at the field; is it not?

15 DR. MacKENZIE: I do not know that it  
16 would lessen the control. I think the situation that  
17 does and has arisen in this province is where when a  
18 problem arises, where there is a difference of opinion  
19 but equal merit on both sides, where I think it is the  
20 duty of the health officer to represent his local people  
21 and take their side of it, as opposed to and perhaps  
22 oppose the provincial government's views on this  
23 particular thing. I do not know who would win, but I  
24 think this should be his duty. It should not be a  
25 provincial matter.

26 COMMISSIONER VAN WART: The local units  
27 have some authority?

28 DR. MacKENZIE: Yes.

29 COMMISSIONER VAN WART: I mean, they  
30 are not in their actions directed and controlled by the



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1 provincial? They have some autonomous authority?

2 DR. MacKENZIE: Yes.

3 COMMISSIONER VAN WART: Then, carrying  
4 along the same thought, page 7, number 38:

5 "Twice a year the provincial health branch  
6 convenes with full time health officers  
7 of the province, the heads of departments  
8 of preventive medicine, University of  
9 British Columbia, the senior medical officers  
10 of the metropolitan areas, and the regional  
11 superintendents of the Indian Health  
12 Services to sit as a health officers  
13 council. This council is advisory to the  
14 health branch."

15 Now, what authority -- they have no more  
16 authority than an advisory?

17 DR. MacKENZIE: That is right.

18 COMMISSIONER VAN WART: It is the co-  
19 ordination of the different health units, provincial health  
20 units, and also the other health services where your  
21 problems are discussed, but they have no power of action.  
22 It is just simply advisory to the local health unit?

23 DR. MacKENZIE: To the province, sir.

24 COMMISSIONER VAN WART: And to the  
25 province, yes.

26 DR. MacKENZIE: Yes, sir. This, I  
27 believe, is patterned after the Dominion Council of Health,  
28 and this council meets twice a year. It does, in effect,  
29 at least, ventilates the views on what will be policy,  
30 and it is mutual give and take. I think that the





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1 provincial government does not always take the views of  
2 the Health Officers' Council, but on the other hand, they  
3 are at least in a position to explain why they do not,  
4 and this gives us a very excellent feeling in this  
5 province one with the other, and what I am getting at  
6 here is I would like to see this preserved and, if  
7 possible, extended, because I know it does not exist  
8 everywhere. It does exist in this province, but not  
9 everywhere. And that municipal or provincial health  
10 departments or units and the University and the provincial  
11 health branch get along remarkably well here, with a  
12 high degree of co-operation, and I think it is one of our  
13 great strengths.

14 It is a little bit difficult -- this is  
15 not written down. Perhaps this is the way we want to do  
16 it and therefore we make it work that way. It is hard to  
17 say. It is not constitutionally laid down as to how this  
18 is done. Some of these things are very vague, but it  
19 works.

20 COMMISSIONER VAN WART: It is different  
21 from other provinces?

22 DR. MacKENZIE: I believe it is, sir.

23 COMMISSIONER VAN WART: But it still  
24 gives the health unit, that is, at the end some say in  
25 what is going to happen in that municipality or district?

26 DR. MacKENZIE: Yes.

27 COMMISSIONER VAN WART: It is not sent  
28 down to the health unit like controls from the top; you  
29 have a say in it -- that is the point I am trying to  
30 bring out, that you have a say in what the policy shall be.

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1 Now, continuing along the same line, there  
2 are a few things which probably are out of the preventive  
3 field, but come, more or less, in the curative field.

4 Do you visualize no change in the hospital  
5 programme as it now exists; that is, your unit is  
6 satisfied for the hospital programme to go on as is; you  
7 do not think it could be worked into the health unit idea  
8 too, but could be outside the field of the health unit?

9 DR. MacKENZIE: With reference to  
10 administration boards?

11 COMMISSIONER VAN WART: Administration  
12 and so on.

13 DR. MacKENZIE: No, sir, I think that the  
14 present administration -- I do not know that it is  
15 perfect, but that the local hospital board, the hospital  
16 district, usually they vary one to maybe six within a  
17 given health unit, that that is the logical way to do it,  
18 I think, to have a hospital board running a hospital or  
19 from a hospital district society, and so on. I think  
20 that certain things such as a greater co-operation between  
21 the community and the hospital and the recognition of the  
22 fact that a patient lived somewhere before he got into  
23 the hospital and is going somewhere after he leaves, but  
24 I think administratively that the hospital running the  
25 health unit or the health unit running the hospital, I  
26 think it is a matter of co-operation between them, and I  
27 think their aims are the same in many ways, but their  
28 problems are somewhat different. I think you have to have  
29 the hospital under its own board, if it is prepared to  
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1 COMMISSIONER VAN WART: I see.

2 Then, you would be satisfied not to have  
3 the hospital incorporated into a health unit, but let  
4 them administer themselves as they are under a channel  
5 of the provincial government, as at the present time?

6 DR. MacKENZIE: Oh, yes, sir.

7 COMMISSIONER VAN WART: Do you believe  
8 that the treatment of patients and disease should be  
9 insured under a voluntary plan or not?

10 DR. MacKENZIE: I do not think that the  
11 health officers have discussed this as fully, perhaps,  
12 enough to really answer as to how it should be financed.  
13 We see the volunteer plan working. They seem to work  
14 very well. The financing of the individual patient's  
15 illnesses does not appear from our point of view as health  
16 officers to be a particularly great problem. But this,  
17 of course, I think, is largely because physicians are  
18 physicians and they will care for these patients. So,  
19 if we see a problem and we have certain sources of money  
20 occasionally, we should do so particularly in the case  
21 of children. I do not think the health officers are  
22 prepared really to discuss financing of the individual.

23 COMMISSIONER VAN WART: On the other hand  
24 the principle of voluntary plans operating, that is out  
25 on the grass-root levels, so to speak, is along the same  
26 lines as your health unit?

27 DR. MacKENZIE: Yes.

28 COMMISSIONER VAN WART: The principle is  
29 the same in both.

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1 and they are most excellent.

2 COMMISSIONER VAN WART: If such a plan  
3 came into effect, say, a voluntary plan and medical  
4 indigents are subsidized, do you think they should be  
5 subsidized through the health units or subsidized similar  
6 to hospitals, another branch independent of the health  
7 units?

8 DR. MacKENZIE: I think one principle  
9 we are stuck with is an important one and it covers this;  
10 the health unit is a service organization and does not  
11 in this province handle money -- it spends money but it  
12 does not actually handle it. I do not think it should be  
13 a bookkeeping thing at all, it should be doctors, nurses,  
14 and so on, providing service. I do not think that in  
15 this province even in the broadest terms we want a health  
16 unit to become an agency for financing anything.

17 COMMISSIONER VAN WART: Coming to another  
18 matter, this question was raised by Dr. Baltzan on the  
19 subject of physical fitness. What is the attitude, your  
20 attitude towards the physical, a mass physical fitness  
21 programme? Is this a desirable thing through co-ordination  
22 with schools and health units and so on?

23 DR. MacKENZIE: I was a little shocked  
24 by the word "mass" physical fitness.

25 COMMISSIONER VAN WART: By "mass", I  
26 mean the general over-all population, physical fitness  
27 starting at grade one in school and up through school.

28 DR. MacKENZIE: We think this is probably  
29 lacking to a certain extent in our present school system  
30 and amongst our young people here. In this province,



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1 particularly in the rural areas, a few years ago when  
2 we were doing tests, our youth came out very well particu-  
3 larly in the rural areas, because there was wood to cut  
4 and hay to pitch. In the urban areas I think the  
5 opportunity for fitness of the youngsters are becoming  
6 more and more difficult. I think we must make provision  
7 and encourage them to take part in it. Whether it is an  
8 integral part of the school or whether it is through  
9 the school on Saturdays and evenings I think is an  
10 administrative problem. I think it must be encouraged  
11 in that group and try to establish a habit to physical  
12 fitness in young people.

13 COMMISSIONER VAN WART: Has your  
14 organization made a particular study of a physical fitness  
15 programme?

16 DR. MacKENZIE: Some of the health units  
17 have and, as I say, it varies regionally, the physical  
18 fitness of the youngsters. It does not vary greatly, but  
19 it does vary and probably the more rural areas are a  
20 little better with reference to physical fitness when  
21 the child is measured by such tests as opposed to the  
22 urban areas, but not a great deal. As to ways and means  
23 I would not say we have studied this but we have discussed  
24 it.

25 COMMISSIONER VAN WART: Then, turning  
26 to page 16, section 4H, you recommend development of  
27 recreational centres in all major populated areas to care  
28 for the handicapped persons discharged from the  
29 rehabilitation centres. Could not the same  
30 idea, a physical fitness programme for those that are



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COMMISSIONER VAN WART: Yes, yes.

organization made a particular study of a physical fitness

program?

have and, as I say, it varies regionally, the physical

fitness of the youngsters. It does not vary greatly, but

it does vary and probably the more rural areas are a

little better with reference to physical fitness than

the child is measured by such tests as opposed to the

urban areas, but not a great deal. As to ways and means

I would not say we have decided this but we have discussed

it.

COMMISSIONER VAN WART: Then, turning

to page 15, section 14, you recommend development of

for the handicapped persons discharged from the

rehabilitation centers. Would not the time

idea of a physical fitness programme for those that



1 are well be worked, something of that nature?

2 DR. MacKENZIE: I think that will be  
3 quite agreeable. We put it here because it has perhaps  
4 a stronger medical factor in this particular group. I  
5 think probably the health units feel they are part but  
6 not the whole of any physical fitness programme. They are  
7 one of the agencies that should be interested in this  
8 but not by any means the only agency interested in it.

9 COMMISSIONER VAN WART: I think British  
10 Columbia is more advanced in the physical fitness pro-  
11 gramme than any other province in Canada.

12 DR. MacKENZIE: I do not know that I am  
13 in a position to judge the rest of Canada. I can say  
14 that what we are doing and it is not bad but whether it  
15 is better or worse than the rest of Canada I could not  
16 say.

17 COMMISSIONER BALTZAN: Physical fitness  
18 is much greater in concept than just a concentration on  
19 athletic prowess?

20 DR. MacKENZIE: I absolutely agree.

21 COMMISSIONER BALTZAN: An athletic  
22 nation is not necessarily a healthy nation.

23 COMMISSIONER FIRESTONE: If I might  
24 refer to recommendation 1 on page 38 where you say that  
25 all types of health services be available to all citizens  
26 of Canada irrespective of geographical location or  
27 financial status. Do I understand that the health  
28 officers of British Columbia are in favour of a compre-  
29 hensive health care programme available to all people of  
30 British Columbia?





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officers of British Columbia are in favour of a compre-

hensive health care programme available to all people of



1 DR. MacKENZIE: No, not necessarily.

2 This is not one of the things we discussed or are  
3 prepared to make a statement on.

4 COMMISSIONER FIRESTONE: Would you then  
5 be good enough to explain to us what you mean that that  
6 type of health service be available to all citizens of  
7 Canada irrespective of their location or financial status.  
8 What do you mean by that?

9 DR. MacKENZIE: I mean irrespective  
10 of where a person is in this province, irrespective of  
11 how much money he has, he should have health services of  
12 the type that we now have made available to him. I do  
13 not say this necessarily means a comprehensive medical  
14 care scheme but I suppose that would be one way to  
15 achieve this. Another way to achieve this would be, as  
16 we are doing now, to see that those who do not have the  
17 financial ability to pay are suitably assisted or  
18 subsidized.

19 COMMISSIONER FIRESTONE: Would you then  
20 say this recommendation means that those that are  
21 financially not able to pay for health services have at  
22 their disposal or have made available to them a  
23 comprehensive health care plan or programme?

24 DR. MacKENZIE: Not necessarily that  
25 they must have made available to them. Perhaps in an  
26 individual case as is sometimes done, to obtain certain  
27 health services as they need. Again, this may be  
28 accomplished by a comprehensive health service or it  
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DR. MEDWELL: No, not necessarily.

That is not one of the things we discussed or are

prepared to make a statement on.

COMMISSIONER FIRSTONE: Would you then

be good enough to explain to us what you mean that that

type of health service be available to all citizens of

Connecticut irrespective of their location or financial status.

What do you mean by that?

DR. MEDWELL: I mean irrespective

of where a person is in this province, irrespective of

how much money he has, he should have health services of

the type that we now have made available to him. I do

not say this necessarily means a comprehensive medical

care scheme but I suppose that would be one way to

achieve this. Another way to achieve this would be, as

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financial ability to pay are entirely assisted or

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financially not able to pay for health services have at

their disposal or have made available to them a

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DR. MEDWELL: Yes, that is what I mean.

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individual case as is sometimes done, to obtain certain

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private money and so on. I know if any individual or



1 child falls ill in our community and there does not seem  
2 to be any other way of financing it I simply have to go  
3 to one of the service clubs and say, "Here is the  
4 situation", and I get the money. The people of the  
5 province will not put up with any gross neglect in this  
6 type of thing.

7 COMMISSIONER FIRESTONE: You are quite  
8 right, you have stated an important principle but you  
9 appreciate that as the Royal Commission that is called  
10 upon to make recommendations with respect to the  
11 implementation of such a principle we like to know how  
12 you yourself in making these recommendations would  
13 suggest this principle be implemented. Would you say  
14 that one way of implementing this principle providing  
15 health care to people that cannot afford to pay for it  
16 is for the state to pay for it?

17 DR. MacKENZIE: Yes.

18 COMMISSIONER FIRESTONE: Would you  
19 support such principle or such a method?

20 DR. MacKENZIE: In those broad terms,  
21 yes.

22 COMMISSIONER FIRESTONE: And would you  
23 say that you attach a high priority to payments being  
24 made or a system or programme or plan being worked out  
25 to provide such medical care services to people who  
26 cannot afford to pay for it?

27 DR. MacKENZIE: That a high priority be  
28 given?

29 COMMISSIONER FIRESTONE: Yes?

30 DR. MacKENZIE: Yes, I think that would



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DR. MACKENZIE: Yes, I think that would



1 be fair enough.

2 COMMISSIONER FIRESTONE: Then you suggest  
3 in paragraph 5:

4 "That a sufficient central organization be  
5 set up and maintained to advise and augment  
6 the local health services."

7 What kind of central organization do you  
8 have in mind?

9 DR. MacKENZIE: I think the local health  
10 service could provide expert opinions in matters of  
11 laboratory advice, in matters of consultation in  
12 specialized diseases as traditionally has been done in  
13 tuberculosis and venereal disease control. I think that is  
14 administrative advice. I also think it is sufficient  
15 for purchasing and accounting and things of that type if  
16 they are done centrally.

17 COMMISSIONER FIRESTONE: By "central  
18 organization" do you mean a provincially administered  
19 organization?

20 DR. MacKENZIE: Yes, I think that would  
21 be the most efficient way of doing it.

22 COMMISSIONER FIRESTONE: That Paragraph 15  
23 you say:

24 "That a greater share of the cost of health  
25 services and sanitary works at the local  
26 level be borne by the federal and provincial  
27 governments."

28 What are the reasons for this recommendation?

29 DR. MacKENZIE: Well, particularly in  
30 the case of smaller municipalities, some need very simple



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1 sanitary work, ditching or sewers or something equally  
2 small which is beyond the taxing powers of that  
3 community. I have known communities that have got  
4 engineering advice and have been told what they need and  
5 it is something in excess of their entire assessment,  
6 so it does produce quite a problem.

7 COMMISSIONER FIRESTONE: How about the  
8 larger municipalities?

9 DR. MacKENZIE: I should think it would  
10 apply all the way up and it would become less apparent  
11 and more complex with the larger communities because it  
12 has a greater number of commitments.

13 COMMISSIONER FIRESTONE: Would you say  
14 one of the reasons for this recommendation is rapid  
15 growth of such services which become increasingly  
16 burdensome to some of the municipalities?

17 DR. MacKENZIE: I think that is true.  
18 In this province our history has been since 1900 the  
19 population has doubled approximately every twenty years.  
20 What we have had to do, I think, is to wait until we  
21 have discussed whatever our facilities are and then have  
22 enough people to tax to put them in. That will be a  
23 much more efficient way if we could do this ahead of  
24 time and get ahead of the problem instead of having a  
25 deplorable situation develop, and I think these provisions  
26 would assist.

27 COMMISSIONER FIRESTONE: In other words,  
28 you are in favour of planning ahead of time rather than  
29 having these difficulties arising?

30 DR. MacKENZIE: That is right. That is



sanitary work, ditching or sewers or something equally small which is beyond the taxing powers of that community. I have known communities that have got engineering advice and have been told what they need and it is something in excess of their entire assessment, so it does produce quite a problem.

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1 why we have mentioned in our brief what we call preventive  
2 sanitation. We have quite enough power and ability to  
3 clear up a pollution problem, but if you do not clear it  
4 up then you have to plan.

5 COMMISSIONER FIRESTONE: Thank you very  
6 much.

7 THE CHAIRMAN: Thank you very much, Dr.  
8 MacKenzie. We are very grateful to you for your brief  
9 and for your appearance here this morning.

10 The next submission is that of the College  
11 of Physicians and Surgeons of British Columbia.

12 THE SECRETARY: This will be exhibit 156.

13  
14 --- EXHIBIT NO. 156: Submission of the  
15 College of Physicians  
16 and Surgeons of British  
17 Columbia.  
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EXHIBIT NO. 156:



SUBMISSION

of the

COLLEGE OF PHYSICIANS AND SURGEONS

OF BRITISH COLUMBIA

APPEARANCES:

DR. LYNN GUNN

DR. W. E. HARRISON

DR. R. G. LANGSTON

DR. HARRISON: Since our summary is

very much a summary and since our brief is so brief, I  
ask leave to present the brief in its entirety.

THE CHAIRMAN: Very well, go ahead.

DR. HARRISON:

Introduction.

The College of Physicians and Surgeons  
of British Columbia is a corporate body created and  
governed by the Medical Act of British Columbia having  
all the powers over and in respect of the practice of  
medicine in British Columbia given it by statute in 1886.  
(Copy attached.)

Essentially the College exists to protect  
the public from those who claim to be qualified medical  
practitioners but are not, and to see to it that those  
who are qualified medical practitioners carry on their  
work in a professional and ethical manner. The powers  
of the College to accomplish these ends are very properly  
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APPENDICES:

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Essentially the College exists to protect the public from those who claim to be qualified medical practitioners but are not, and to see to it that those who are qualified medical practitioners carry on their work in a professional and ethical manner. The powers of the College to accomplish these ends are very properly limited by legislation, but because of changes in





1 medical practice there is need for a revision of the  
2 Medical Act to enable the College to adequately exercise  
3 its disciplinary function. I would rather not enlarge  
4 on that unless it is necessary.

5 3. Responsibilities of the College of Physicians and  
6 Surgeons of British Columbia.

7 (a) Supervision of the maintenance of standards for  
8 medical education.

9 (b) Registration of physicians for medical practice in  
10 British Columbia.

11 (c) Discipline of members of the medical profession in  
12 British Columbia.

13 4. Standards of Medical Education

14 (a) The College has steadfastly main-  
15 tained its position that a minimum standard of education  
16 and training must have been attained before a candidate  
17 could be licensed to practice medicine in this province.  
18 It believes that it is only by adhering to these standards  
19 that the people of this province can be assured of the  
20 high level of medical care to which they are entitled.  
21 The examinations and requirements asked of those coming  
22 from other lands are the same as the ones which our own  
23 Canadian applicants must fulfill. The College is  
24 frequently under pressure from various quarters to relax  
25 its standards for specific individuals who do not meet  
26 the standards of training as developed over the years.  
27 The profession feels it is unjust to allow a foreign  
28 trained physician to practise in Canada, even in a  
29 hospital under supervision, until he or she has shown  
30 a sufficient knowledge of basic medical subjects.

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- (a) Supervision of the maintenance of standards for
- (b) Registration of physicians for medical practice in British Columbia.
- (c) Discipline of members of the medical profession in British Columbia.

4. Standards of Medical Education

(a) The College has steadily maintained its position that a minimum standard of education and training must have been attained before a candidate could be licensed to practice medicine in this province. It believes that it is only by adhering to these standards that the people of this province can be assured of the high level of medical care to which they are entitled. The examinations and requirements asked of those coming from other lands are the same as the ones which our own Canadian applicants must fulfill. The College is frequently under pressure from various quarters to relax its standards for specific individuals who do not meet the standards of training as developed over the years. The profession feels it is unjust to allow a foreign trained physician to practise in Canada, even in a hospital under supervision, until he or she has shown a sufficient knowledge of basic medical subjects.



1 (b) A new responsibility has been placed  
2 on all the Provincial Licensing Bodies by the Medical  
3 Council of Canada to see that the initial postgraduate  
4 medical education is adequate. A satisfactory intern-  
5 ship in an approved general hospital is a requirement for  
6 a license to practise medicine in B.C.

7 I might add the Medical Council of Canada  
8 now requires a brief internship in hospital before  
9 granting the licentiate of the Medical Council of Canada.

10 (c) The College has passed the control  
11 and burden of supervision of the requirements to be met  
12 by medical specialists in this province to another body,  
13 the Royal College of Physicians and Surgeons of Canada,  
14 whose main function is to determine the amount of  
15 training and proficiency required before a candidate  
16 may be issued a specialist certificate. This certificate  
17 is of increasing importance since medical services are  
18 being paid for more and more by third parties a generally  
19 accepted identification as a specialist is an increasing-  
20 ly valuable asset. The College performs a service in  
21 maintaining a complete list of specialists and publishing  
22 it regularly.

23 These are all specialists recognized in  
24 this province.

25 5. Registration of Physicians

26 (a) All candidates for registration must  
27 have the Certificate of the Medical Council of Canada  
28 in addition to a certificate of one year's satisfactory  
29 rotating internship in an approved Canadian, British  
30 or United States hospital.





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(a) All candidates for registration must have the Certificate of the Medical Council of Canada in addition to a certificate of one year's satisfactory rotating internship in an approved Canadian, British or United States hospital.



1 (b) Satisfactory evidence as to character,  
2 identification and adequate knowledge of the English  
3 language.

4 (c) Candidates who are graduates of  
5 other than Canadian, British or United States medical  
6 schools are required to pass a screening examination  
7 in six basic science medical subjects. This must be  
8 done prior to being permitted to interne as proof  
9 of having obtained a basic medical education compar-  
10 able to a Canadian medical graduate.

11 If I might refer to that a moment or two.  
12 This Council feels it doesn't have adequate information  
13 as to what provision for education is provided in schools  
14 in other places than the British Isles, the United States,  
15 and Canada, therefore, we ask graduates of these other  
16 schools to take the same basic science examinations that  
17 we require of our Canadian graduates before they are  
18 allowed to proceed to take hospital training or write  
19 the Medical Council of Canada as far as British Columbia  
20 is concerned.

21 6. Disciplinary Functions of the College.

22 All practitioners are, of course, subject  
23 to the general laws applicable to all citizens.  
24 Minor breaches of these general laws are not considered  
25 by the Council, but when a practitioner has been  
26 convicted of an indictable offence he may have his  
27 name removed from the Register under section 48 of  
28 the Medical Act. This function is straightforward.  
29 In addition, the Council of the College has the power  
30 to remove a practitioner's name from the Register



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This Council feels it doesn't have adequate information as to what provision for education is provided in schools in other places than the British Isles, the United States and Canada, therefore, we ask graduates of these other schools to take the same basic science examinations that we require of our Canadian graduates before they are allowed to proceed to take hospital training or write the Medical Council of Canada as far as British Columbia is concerned.

6. Prescriptive Function of the College.

All practitioners are, of course, subject to the general laws applicable to all citizens. Minor breaches of these general laws are not considered by the Council, but when a practitioner has been convicted of an indictable offence he may have his name removed from the Register under section 43 of the Medical Act. This function is straightforward. In addition, the Council of the College has the power to remove a practitioner's name from the Register.



1 when it decides, after due enquiry, he has been found  
2 unfit to practise under Section 50 of the Medical  
3 Act. What constitutes lack of fitness to practise  
4 medicine must be decided on the basis of a satisfac-  
5 tory standard of professional conduct derived from  
6 tradition, general acceptance and written codes of  
7 ethics. All of these may change from time to time.  
8 This is a professional matter which can only be  
9 decided by the medical profession. In our opinion,  
10 only in very special circumstances should the  
11 decision of a medical investigating body be changed  
12 by a court of law.

13 THE CHAIRMAN: Doctor, what is the  
14 appeal provision now in British Columbia?

15 DR. HARRISON: The appeal is directly  
16 to the Supreme Court of British Columbia and from there  
17 to the Appeal Court of British Columbia and then to the  
18 Supreme Court of Canada. Some right of appeal, however,  
19 should be maintained.

20 THE CHAIRMAN: Are you advocating a  
21 change there?

22 DR. HARRISON: Yes, sir, we believe  
23 that medical men are in a better position to judge a  
24 medical man's misconduct, not necessarily to the wording  
25 of the law, but to the feeling of the law than anybody  
26 else.

27 Mind you, medical men make mistakes too,  
28 and I think there should be some right of appeal maintain-  
29 ed.

30 THE CHAIRMAN: Where would you draw the



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THE CHAIRMAN: Where would you draw the



1 line?

2 DR. HARRISON: I am sorry, I couldn't  
3 draw the line, sir, at this stage.

4 7. Future Requirements for Physicians in Canada.

5 We are facing a major problem in Canada  
6 today with regard to medical manpower. Our physician/  
7 population ratio in Canada has shown only a slight  
8 gradual strengthening over the years; in 1901 it  
9 was 1/981 in 1960 it was 1/879.

10 This is a quotation from the Canadian  
11 Medical Journal of November, 1961.

12 Even in this province where we are in a  
13 better position than the national average, virtually  
14 the same picture obtains. There is perhaps a need  
15 for an improved ratio which will cope with the ever-  
16 increasing complexity of modern medicine, with the  
17 continuing trend towards specialization, with the  
18 larger and larger number of physicians engaged in  
19 activities other than patient service such as  
20 medical research, public health, medical administra-  
21 tion and industrial medicine.

22 In the immediate past we have been aided  
23 by a flow of immigrant physicians, mostly from  
24 Britain, but also from foreign medical schools.  
25 Approximately one third of the physicians newly  
26 registered to practise medicine in Canadian provinces  
27 in the period from 1950-60 were graduates of medical  
28 schools outside of Canada.

29 I may say in British Columbia the percen-  
30 tage in 1950 to 1961 inclusive varied from fourteen

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better position than the national average, virtually

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age in 1960 to 1961 inclusive varied from fourteen





1 to forty per cent with an average of 30.58 per cent  
2 coming from outside Canada; that is, Britain, United  
3 States and other foreign countries.

4 There is no good evidence that this flow  
5 will be adequate to meet the increasing population  
6 requirements of the future or improve the present  
7 physician/population ratio.

8 THE CHAIRMAN: Of that thirty-five per  
9 cent, how many came from Great Britain, I mean percentage-  
10 wise, if you know.

11 DR. HARRISON: I haven't worked it out,  
12 sir. Perhaps I could give you two years, 1950 and 1961  
13 are the two years I have here, the furthest apart.  
14 In 1950 a total of one hundred and one new registrants  
15 in British Columbia. Ten of those were from Great  
16 Britain, three from the U.S.A., and two from other  
17 countries.

18 THE CHAIRMAN: Your figures are given  
19 in the supplementary sheet?

20 DR. HARRISON: Yes.

21 THE CHAIRMAN: Thank you very much.

22 8. Recommendations to Increase Output of Medical Graduates  
23 in Canada.

24 Thus we must find means to increase the  
25 output of medical graduates in Canada. Basically,  
26 two methods might be used; to increase the class  
27 sizes in our existing schools or to create additional  
28 schools. However, both solutions face the same  
29 obstacle since medical education is by far the most  
30 expensive operation of a university. Unless the



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cent, how many came from Great Britain, I mean percentages  
else, if you know.

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are the two years I have here, the relevant years.  
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1 Canadian Universities can obtain increased financial  
2 aid they will find it extremely difficult to either  
3 extend present schools or to begin new schools. The  
4 training of physicians is definitely a matter of  
5 national import, provincial boundaries are unimportant  
6 in this regard, a physician trained in one province  
7 may well practise in another. Therefore, the College  
8 would strongly recommend that the Federal Government  
9 give serious consideration to substantial financial  
10 aid to Canadian medical schools.

11 There are two other areas in which, in the  
12 opinion of this College, the Federal Government should  
13 give financial aid. Medical education is costly and  
14 long to the student. In the recruitment of students,  
15 the medical schools are in direct competition with  
16 the other science fields. In most of these, students  
17 can expect substantial financial subsidization through  
18 the National Research Council and similar organiza-  
19 tions. No such source of funds is available to  
20 medical students. If we are to attract students to  
21 careers in medicine, the Federal Government should  
22 provide equivalent financial support to them. Further,  
23 after his four years as an undergraduate student,  
24 the new physician faces up to five years further  
25 training before he is a fully qualified specialist.  
26 Deserving graduates must receive financial support  
27 if we are to have a continuing supply of the highly  
28 trained specialists required in modern medicine.  
29 Young people of their age and education should be  
30 entitled to live a married life reasonably comfortably





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It is we are to have a continuing supply of the highly trained specialists required in modern medicine. Young people of their age and education should be entitled to live a married life reasonably comfortably



1 on their own earnings.

2 The Council of the College of Physicians  
3 and Surgeons of British Columbia is most appreciative  
4 of this opportunity of presenting this submission  
5 and wish to assure the Commission of its complete  
6 co-operation should any additional material be re-  
7 quired.

8 THE CHAIRMAN: Thank you very much.  
9 Dr. Firestone?

10 COMMISSIONER FIRESTONE: Dr. Harrison,  
11 in recommendation 8 you suggest that the Canadian  
12 universities, particularly the medical schools would  
13 require increased financial aid in order to train more  
14 doctors. Did you have in mind capital grants or operating  
15 grants or both?

16 DR. HARRISON: Both.

17 COMMISSIONER FIRESTONE: Would you feel  
18 that a fairly substantial increase in such grants would  
19 be desirable from the Federal Government?

20 DR. HARRISON: I feel that the universi-  
21 ties, with the funds available to them, are not able to  
22 provide these extra services unless money is available  
23 from the Federal Government.

24 COMMISSIONER FIRESTONE: As you realize,  
25 sir, some grants are already made available, but they are  
26 general university grants. Would you have in mind  
27 specific grants that are made for the expansion of  
28 medical schools?

29 DR. HARRISON: Yes.

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COMMISSIONER FINESTONE: Would you have





1 any particular amounts that would be required?

2 DR. HARRISON: I think that would  
3 require a great deal of study, Professor Firestone. I  
4 don't think I would be able to give specific amounts.

5 COMMISSIONER FIRESTONE: Well, Dr.  
6 Harrison, you appreciate the position of this Commission.  
7 We are here to advise the Federal Government as to what  
8 could be done and how it could be done and it would help  
9 us if we were able to say, whatever recommendations we  
10 make, it has been presented to us that the B.C. University  
11 of British Columbia Medical School has need of funds for  
12 its expansion programme over the next ten years and it  
13 requires Federal assistance in this and that order, for  
14 this and that aspect. If we had specific information we  
15 could present a case. To make a general statement,  
16 perhaps, wouldn't yield the same results. I was wondering  
17 whether such information could possibly be gotten, not  
18 necessarily by yourself, but perhaps in consultation  
19 with the people who are involved as well, at the  
20 university level.

21 DR. HARRISON: I feel quite sure if  
22 it were discussed with our Dean of Medicine he could give  
23 us some ideas from the university. I am not prepared to  
24 mention figures today.

25 COMMISSIONER FIRESTONE: It would be  
26 very satisfactory to this Commission if it was acceptable  
27 to you and your colleagues to have this discussion with  
28 the Medical Faculty of U.B.C., and advise us at a later  
29 date in writing whatever information you can give us.  
30 Would that be acceptable?

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Would that be acceptable?



1 DR. HARRISON: I would be quite happy  
2 to.

3 COMMISSIONER FIRESTONE: The second  
4 point you are making, you need not only bricks and mortar  
5 and equipment, you also need students, and that perhaps  
6 some financial aid to students would increase the supply  
7 of potential medical students. What would you consider  
8 to be an adequate scholarship for undergraduate students  
9 in medicine?

10 DR. HARRISON: I see, sir, you want  
11 figures. I am afraid we are not prepared to give figures  
12 on this. I had in mind, actually, that the grants would  
13 reduce the medical student's fee materially so he would  
14 have more of his earned money to maintain himself.

15 COMMISSIONER FIRESTONE: Would you feel,  
16 sir, if there was an adequate scholarship system avail-  
17 able to medical students that are competent and promising  
18 that this might increase the supply of medical students?

19 DR. HARRISON: Yes, I do, because I  
20 believe many potential medical students go into other  
21 scientific careers because there is less expense and they  
22 have less hardship to maintain themselves during their  
23 courses.

24 COMMISSIONER FIRESTONE: Now, sir, as  
25 you suggested you haven't given consideration to actual  
26 figures. Would it be possible if I spell out one or two  
27 cases that would be helpful, that you might be able to  
28 make it available to us later?

29 DR. HARRISON: Yes, I think so.

30 COMMISSIONER FIRESTONE: It would help



us, sir, if you could indicate what you would consider

an adequate amount of scholarships for undergraduate medical students to cover both costs and fees of tuition,

as well as living expenses, and a similar amount required for a graduate medical student, presumably some of these are married and with children, and it may be more costly to pursue post-graduate studies.

Therefore, we are asking, A, for two

different amounts: for undergraduate students and for graduate students; and secondly, what would be, in your opinion, a reasonable number of scholarships that should be made available per year to students attending the Medical Faculty at U.B.C.

If you have any views as to what this should be for Canada, you are welcome to add those as well. Thank you very much.

referring to the second portion of your presentation, the exhibit, will you please tell me, do you show how internes and hospital residents who are registered but not practicing, in the total number of physicians?

DR. HARRISON: I will ask Dr. Gunn to

answer.

DR. GUNN: That includes mainly chapas who are still in the training pool. There are very few in this list who are fully registered.

COMMISSIONER BATTAN: I am not counting

the ones that are registered. Do you have some residents that have obtained registration but they are actually



1 students or post-graduate students?

2 DR. GUNN: Not fully registered.

3 COMMISSIONER BALTZAN: To serve people  
4 outside of the hospital?

5 DR. HARRISON: This includes, these are  
6 fully registered ones here.

7 COMMISSIONER BALTZAN: Amongst some of  
8 them, perhaps in some of the larger hospitals, these  
9 people are still post-graduate students?

10 DR. HARRISON: Some of them are.

11 COMMISSIONER BALTZAN: So they are not  
12 available for public service outside of the hospital as  
13 post-graduate students?

14 DR. HARRISON: Not immediately.

15 COMMISSIONER BALTZAN: So the figure  
16 available for British Columbia is a little bit less than  
17 the total amount?

18 DR. HARRISON: The ones from two or  
19 three years before will be coming out, so perhaps it  
20 balances itself fairly well.

21 COMMISSIONER BALTZAN: In this total  
22 number here, Dr. Harrison and colleagues, do you have a  
23 breakdown of the number of doctors who give patient  
24 services versus the number of those who have sat their  
25 M.D. and are registered, but who serve in public health  
26 departments or in administrative positions?

27 DR. HARRISON: Do we have a breakdown,  
28 no.

29 COMMISSIONER BALTZAN: Have you any idea?

30 DR. HARRISON: Perhaps Dr. Gunn might







1 have some idea.

2 DR. GUNN: Well, roughly, I would say  
3 there are about, just under one hundred.

4 COMMISSIONER BALTZAN: Because these are  
5 included in the total physicians, so many doctors per  
6 population, and these people are included in that figure.

7 DR. GUNN: Yes, sir.

8 COMMISSIONER BALTZAN: But they are not--

9 DR. GUNN: In private practice.

10 COMMISSIONER BALTZAN: Giving patient  
11 service?

12 DR. GUNN: That is right.

13 COMMISSIONER BALTZAN: That not only  
14 applies to you, but, the way we estimate things, all  
15 across Canada. You say probably one hundred out of your  
16 two or nearly three thousand?

17 DR. GUNN: Yes, the twenty-one hundred  
18 that are in actual practice.

19 COMMISSIONER BALTZAN: One other question.  
20 This is a matter that you stress on page 3 about foreign  
21 doctors who make applications to our hospitals to become  
22 residents in Canada. It is well known that they are a  
23 considerable amount of a problem. Is it a big problem  
24 here? We have heard in other places that one hospital  
25 of about three hundred beds had as many as one hundred  
26 applicants for positions in that hospital, and they were  
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DR. HARRISON: I know it is a small



1 proportion, Dr. Baltzan. The standards of education in  
2 other parts of the world are very much below the  
3 standards of education in the English speaking countries,  
4 not all, but quite a number of them.

5 In the United States last year out of  
6 some fourteen thousand who wrote their E.C.F.M.G.  
7 examinations, which is the qualifying examination to take  
8 an internship in their country, about one-third of these  
9 were considered unfit to enter the United States to take  
10 training. It gives you an idea of the percentage that  
11 pertains down there.

12 COMMISSIONER BALTZAN: I am grateful  
13 to you for your information.

14 One last bit of information, you refer  
15 to the certificate given by the Royal College of  
16 Physicians and Surgeons of Canada, and taken out of  
17 context it would mean, because you merely specify, and  
18 it applies here, these qualifications are helpful in  
19 relation to payments by third parties.

20 I think we are all old enough to say at  
21 the time that wasn't a big consideration when these  
22 Colleges were formed.

23 DR. HARRISON: No.

24 COMMISSIONER BALTZAN: The purpose was  
25 then what?

26 DR. HARRISON: You mean the financial  
27 return?

28 COMMISSIONER BALTZAN: Yes.

29 DR. HARRISON: No, it was then to raise  
30 the standards of education. That was the main purpose



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1 at the time. Taken in special fields particularly.

2 COMMISSIONER BALTZAN: And it did help,  
3 then, to be able to say who has had enough training, to  
4 be able to call himself what we call a specialist in  
5 surgery or medicine, or something else?

6 DR. HARRISON: Yes, sir.

7 COMMISSIONER BALTZAN: Up until that  
8 time, did you have any guides?

9 DR. HARRISON: I believe some of the  
10 provinces maintained a list of specialists that lived up  
11 to certain requirements in that particular province, but  
12 I believe we never had that in British Columbia until  
13 the Royal College took over.

14 DR. GUNN: A number of years ago, the  
15 Council of the College set up a special committee to  
16 determine whether a man could rightfully call himself a  
17 specialist. They maintained a list. This was a rather  
18 arduous task, and they did not have the necessary machin-  
19 ery to go into it fully, so they were very happy when  
20 the Royal College was formed and they turned that duty  
21 over to the Royal College of Physicians and Surgeons.

22 COMMISSIONER BALTZAN: You found that  
23 necessary in the public interest?

24 DR. GUNN: In the public interest,  
25 definitely.

26 COMMISSIONER BALTZAN: Thank you very  
27 much.

28 DR. LANGSTON: I wonder if I could make  
29 a comment on one of Commissioner Baltzan's questions.  
30 One of his first questions was about this supplementary

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a comment on one of Commissioner Baltman's questions.

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1 list, and I think you ought to understand this is the  
2 number of registrations that take place each year in  
3 British Columbia, and most of those registrations are  
4 people who have just obtained their right to practice.  
5 There is a large percentage of those which are not  
6 available for public service, or to go into practice  
7 until they have finished their post-graduate training,  
8 which may take up to five years or more. So that,  
9 roughly, maybe forty per cent or half of these people  
10 go into hospitals for training as for graduate work.  
11 So, they are not available to go out into practice for  
12 a number of years. Of course, after a few years, the  
13 ones who have done this in previous years take up the  
14 slack.

15 COMMISSIONER BALTZAN: In the meantime,  
16 they are not available?

17 DR. LANGSTON: They are not available  
18 for practice, no.

19 COMMISSIONER BALTZAN: That is what I  
20 wanted to know, sir. Thank you.

21 COMMISSIONER VAN WART: On page 4,  
22 section 5-B. Does that clause mean that French speaking  
23 doctors in Canada must be bilingual before they are  
24 allowed to practice in British Columbia?

25 DR. HARRISON: Yes, we insist on that --  
26 a knowledge of the English language here.

27 COMMISSIONER VAN WART: I see. That is  
28 all, Mr. Chairman.

29 THE CHAIRMAN: Thank you very much,  
30 gentlemen. As you may know, we have a study in medical

list, and I think you ought to understand this is the number of registrations that take place each year in British Columbia, and most of those registrations are people who have just obtained their right to practice. There is a large percentage of those which are not available for public services, or to go into practice until they have finished their post-graduate training, which may take up to five years or more. So that, roughly, maybe forty per cent or half of those people go into hospitals for training as for graduate work. So, they are not available to go out into practice for a number of years. Of course, after a few years, the ones who have done this in previous years take up the slack.

they are not available

COMMISSIONER BATTAN: That is what I

wanted to know, sir. Thank you.

COMMISSIONER VAN WART: On page 4,

section 5-B. Does that clause mean that French speaking

doctors in Canada must be bilingual before they are

allowed to practice in British Columbia?

DR. HARRISON: Yes, we insist on that --

a knowledge of the English language here.

COMMISSIONER VAN WART: I see. That is

all, Mr. Chairman.

THE CHAIRMAN: Thank you very much.

Gentlemen. As you may know, we have a study in medical



1 education underway with Dr. McFarlane, recently Dean at  
2 Toronto, and Dr. McCleary from the University here is  
3 part of that team. I think we will be pretty well  
4 informed as to the situation in British Columbia through  
5 Dr. McCleary, and as to all the statistics and so forth  
6 from the study that has been made, and your submission  
7 will go to that study project.

8 DR. GUNN: Thank you, sir.

9 THE CHAIRMAN: We will next here from  
10 the British Columbia Old Age Pensioners Organization.

11  
12 --- EXHIBIT NO. 157: Submission of the  
13 British Columbia  
14 Old Age Pensioners  
15 Organization.  
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THE CHAIRMAN: We will next hear from

the British Columbia Old Age Pensioners Organization.

Submission of the  
British Columbia  
Old Age Pensioners

EXHIBIT NO. 154



SUBMISSION

of the

BRITISH COLUMBIA OLD AGE PENSIONERS ORGANIZATION

APPEARANCES:

MR. J. FIELD

THE CHAIRMAN: Mr. Field, please.

MR. FIELD: Mr. Chairman, ladies and gentlemen, I am here today representing the Old Age Pensioners Organization. We were instituted in 1932 and incorporated in 1937, representing approximately nine thousand members with seventy-six branches.

I have with me today the brief, which was made out for me and with your permission if I may read it?

THE CHAIRMAN: If you will, Mr. Field.

MR. FIELD:

We are very concerned as to how the findings and recommendations of your Commission may affect old age pensioners.

As you are aware, many old age pensioners are insured under a number of private schemes to which they have contributed for years, some in fact being fully paid up, so that they are receiving medical care without further cost to them.

THE CHAIRMAN: Mr. Field, would you mind if we posed the questions as you go along?

MR. FIELD: Take one at a time?



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THE CHAIRMAN: Mr. Field, would you mind

if we posed the questions as you go along?

MR. FIELD: Take one at a time?





1 THE CHAIRMAN: Sort of, yes. You may  
2 sit down, if you prefer.

3 MR. FIELD: Yes.

4 THE CHAIRMAN: Now, it is just on this  
5 statement that you made that money is paid up in advance.  
6 How does that come about? What is the mechanism by which  
7 you get paid up in advance?

8 MR. FIELD: Well, as I understand it,  
9 I only understand it as read.

10 THE CHAIRMAN: I see.

11 MR. FIELD: I am not very familiar with  
12 the proper information as to give it to you, because I  
13 am only a representative. I am not the president.

14 THE CHAIRMAN: When you refer to private  
15 schemes, you mean M.S.I. and the other voluntary schemes  
16 in British Columbia?

17 MR. FIELD: Yes.

18 THE CHAIRMAN: Well, we will get the  
19 information, then, from them.

20 MR. FIELD: Can I go further?

21 THE CHAIRMAN: Yes, please.

22 MR. FIELD:

23 We would implore you to look fully into  
24 all such schemes as are now operating, so that such  
25 schemes may be fully integrated with any proposals you  
26 make; we are very anxious that the position of those  
27 already covered by health insurance be not jeopardized.

28 We remember only too well that when  
29 hospital insurance was instituted in this province, many  
30 of the existing schemes had to be scrapped, and we also

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1 remember that once the government had guaranteed payment,  
2 costs of hospital treatment soared remarkably, and  
3 likewise the government premiums took on an ever increas-  
4 ing upward spiral; for a time a very sticky situation  
5 ensued. Of course, this situation has been resolved by  
6 the elimination of premiums as such, so that now it is  
7 very difficult to calculate just how much our hospital  
8 insurance does cost us individually.

9 In short we desire to see no one hurt by  
10 the introduction of a national insurance scheme.

11 May we also commend to your attention the  
12 case of the old age pensioners ~~with~~ supplementary  
13 allowance, including medical cards, and ask that you  
14 recommend nothing detrimental to their best interests.

15 Respectfully submitted by

16 The British Columbia Old Age Pensioners  
17 Organization.

18 A. H. Porter, President.

19 S. P. Jones, 2nd Vice President.

20 THE CHAIRMAN: I understand, Mr. Field,  
21 that you are not in a position to answer specific  
22 questions because you did not prepare this brief and you  
23 are presenting it here for Mr. Porter?

24 MR. FIELD: I am just submitting it on  
25 their behalf, yes.

26 THE CHAIRMAN: So that the further  
27 information that we may need here we will get from Mr.  
28 Porter. We will write him. There is some information  
29 we would like to have, and we will communicate with Mr.  
30 Porter and ask him to send that information to us in





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28 Porter. We will write him. There is some information  
29 we would like to have, and we will communicate with Mr.  
30 Porter and ask him to send that information to us in



1 writing.

2 MR. FIELD: Yes.

3 THE CHAIRMAN: And you may, if you will,  
4 advise him accordingly.

5 MR. FIELD: Thank you, sir.

6 THE CHAIRMAN: Thank you very much.

7 We will now take a short recess before we  
8 proceed with the next submission.

9  
10 --- A short recess.

11  
12 THE CHAIRMAN: May we come to order and  
13 proceed.

14 The submission of the Canadian Arthritis  
15 and Rheumatism Society, British Columbia Division.

16  
17 --- EXHIBIT NO. 158: Submission of the  
18 Canadian Arthritis and  
19 Rheumatism Society,  
20 British Columbia  
21 Division.  
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28  
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30



MR. FIELD: Yes.

THE CHAIRMAN: And you say, if you will,

advise him accordingly.

MR. FIELD: Thank you, sir.

THE CHAIRMAN: Thank you very much.

We will now take a short recess before we

proceed with the next submission.

--- A short recess.

THE CHAIRMAN: May we come to order and

The submission of the Canadian Arthritis

and Rheumatism Society, British Columbia Division.

--- EXHIBIT NO. 128:

Submission of the  
Canadian Arthritis and  
Rheumatism Society,  
British Columbia  
Division.





SUBMISSION

of the

CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

BRITISH COLUMBIA DIVISION

APPEARANCES:

MR. J. McAVITY

DR. H. C. SLADE

DR. BROCK M. FAHRNI

DR. J. P. GOFTON

MISS MARY PACK

MR. McAVITY: Mr. Chairman and members of the Commission, before making a brief introduction which will outline our three main recommendations, I would like to introduce the members of the committee.

Dr. Colin Slade, who is chairman of our medical advisory committee for the province; Dr. Brock Fahrni, who is also a member of the medical advisory committee for the province; Dr. Gofton, who is a member of the medical advisory committee, and Miss Mary Pack, who is our executive director for the division.

Following my brief introduction, three of these gentlemen will enlarge on some of the points that we have presented in our brief.

Early in 1948, the Canadian Arthritis and Rheumatism Society was incorporated for the purpose of controlling arthritis and rheumatic disease in Canada.



SUBMISSION

of the

ARHEMATIC AND RHEUMATISM SOCIETY

BRITISH COLUMBIA DIVISION

MEMBERS:

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committee for the province; Dr. Gilton, who is a member

of the medical advisory committee, and Miss Mary Bark,

who is our executive director for the division.

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these gentlemen will endorse on some of the points that

we have presented in our brief.

Early in 1948, the Canadian Arthritis and

Rheumatism Society was incorporated for the purpose of

controlling arthritis and rheumatic disease in Canada.



1 Guided by an excellent medical advisory board the lay  
2 directors put into effect a programme of research and  
3 education and each province initiated its own plan for  
4 treatment. Because the National Board of C.A.R.S. will  
5 be presenting a brief on behalf of the National Society,  
6 the remarks and recommendations of the B.C. division  
7 will be directed mainly to the needs in this province.

8           The treatment programme, adopted in B.C.  
9 and supported consistently by the provincial government  
10 and the general public, is described in the appendices  
11 of our submission. The services rendered to over twenty-  
12 seven thousand persons in B.C. since the Society's  
13 incorporation have neither duplicated facilities already  
14 in existence nor have they interfered with any one's  
15 private practice. We believe these services have saved  
16 many hundreds from becoming crippled, have returned many  
17 hundreds to useful lives, and consequently, have benefited  
18 the economy of the province.

19           The welfare of the arthritis patient has  
20 always been our prime concern. Our doctors, specialists  
21 in internal medicine and with vast experience in  
22 rheumatic disease have learned that, contrary to theory  
23 and general belief, patients with rheumaty arthritis  
24 can make much greater progress if treated in a special  
25 centre rather than being scattered throughout the wards  
26 of a general hospital. It is imperative that such a  
27 unit be established in Vancouver now to save from  
28 disability those with acute disease and this is our first  
29 recommendation. This unit would provide the example for  
30 teaching and research now absent in the training of





1947

Report of the Committee on the B.C. Division of the Royal Society

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teaching and research now absent in the training of



1 doctors and para-medical personnel, and would be a  
2 source of enlightenment for all professional people in  
3 the medical field and of benefit for all those with  
4 rheumatic disease.

5 C.A.R.S. has never refused a request for  
6 service while staff has been available but so great has  
7 become the demand and so short the supply of properly  
8 trained staff that eleven of the twenty-three districts  
9 outside Vancouver are now without mobile units and may  
10 remain closed for the next year or two even if our  
11 second recommendation with respect to training of  
12 personnel is implemented immediately.

13 Those who work only in the cities or with  
14 the chronic patient in his hospital bed are performing  
15 wonderful service but they do not realize that the  
16 benefit of institutional care may be wasted unless the  
17 concept of rehabilitation is carried through by the  
18 treatment team to the patient's home or until he can  
19 work again.

20 C.A.R.S. provincial programme has proved  
21 to us over and over again, that a carefully integrated  
22 network of personnel and facilities is sensible,  
23 necessary and economical. This type of integrated  
24 programme is possible and constitutes our third recommen-  
25 dation.

26 Because it is our sincere wish to assist  
27 those whose return to useful lives depends upon the  
28 implementation of these three major recommendations  
29 (paragraphs 7, 8, and 9) we earnestly appeal to you to  
30 consider them favourably. The recommendations in part

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consider them favorably. The recommendations in part





1 two, section B, paragraph 13, are supplementary to and  
2 will help to make the three main recommendations workable.

3 With your permission, Mr. Chairman, I  
4 would like to call on Dr. Cofton to enlarge on the main  
5 recommendations which are contained in paragraph 7 of  
6 our submission.

7 DR. COFTON: Mr. Chairman, the British  
8 Columbia Division of C.A.R.S. has had extensive and  
9 intimate experience with the problems posed by disability  
10 which is created by the general group of rheumatic  
11 diseases. Having been engaged in it for some fourteen  
12 years in the treatment of patients throughout the province,  
13 having a case load of approximately twenty-five hundred  
14 new patients per year, we recognize that the disability  
15 which is produced by arthritis is only one of a number  
16 of disabilities produced by a number of chronic diseases,  
17 but we feel that our experience with the arthritic group  
18 is generally representative of the experience which could  
19 be expected if better facilities were available across  
20 the board for these other diseases. We have direct  
21 knowledge of the value of present treatment methods,  
22 and we believe we can show this by statistics and have  
23 done so in the brief.

24 We are aware of the factors which have  
25 prevented the extension of these services in the province,  
26 and we have mentioned those. We are aware of the  
27 necessity for better co-ordination of services so that  
28 early acute cases can have the early application of  
29 treatment methods which will limit the disability which  
30 would otherwise result, and in methods of restoration

two, section B, paragraph 13, are supplementary to and will help to make the three main recommendations workable.

With your permission, Mr. Chairman, I

would like to call on Dr. Cotton to enlarge on the main

recommendations which are contained in paragraph 7 of

our submission.

DR. COTTON: Mr. Chairman, the British

Columbia Division of C.A.R.S. has had extensive and

intimate experience with the problems posed by disability

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1 of people who are already disabled to a far better  
2 functional capacity. We have some statistics on this.  
3 We have some opinions on the requirements and the best  
4 methods for the extension of service throughout the  
5 province, and we have mentioned these.

6 With respect to the three major recommen-  
7 dations, the one concerning the desirability of an in-  
8 patient treatment centre I will leave that to Dr. Slade.  
9 The second main recommendation concerning medical  
10 rehabilitation personnel: We have in the province now  
11 an establishment with proven use for some thirty-two  
12 physiotherapists and are drastically short in spite of  
13 our efforts to recruit physiotherapists from other parts  
14 of the world. We have attempted to provide the same  
15 kind of statistic across the country to show the current  
16 lack of rehabilitation personnel for divisions which are  
17 currently available. We submit that to plan rehabilita-  
18 tion for arthritis or other diseases without an adequate  
19 supply of personnel is to build a cart without wheels,  
20 it will move very little, unless some efforts are made  
21 urgently to improve the recruitment of people for  
22 training in rehabilitation, particularly physiotherapists,  
23 occupational-therapists, and the other ancillary  
24 personnel. Our experience in British Columbia is perhaps  
25 unusual in that we have attempted to provide this  
26 facility, this rehabilitative facility for the arthritic  
27 patients throughout the province at all community levels  
28 whereas the experience in many areas of the country and  
29 of the continent has been confined to the problem of  
30 rehabilitation in special centres alone.





of people who are already disabled to a far better functional capacity. We have some statistics on this. We have some opinions on the requirements and the best methods for the extension of services throughout the province, and we have mentioned these.

With respect to the three major recommendations, the one concerning the desirability of an inpatient treatment centre I will leave that to Dr. Slade.

The second main recommendation concerning medical rehabilitation personnel. We have in the province now an establishment with provision for some thirty-two physiotherapists and are desperately short in spite of our efforts to recruit physiotherapists from other parts of the world. We have attempted to provide the same kind of statistic across the country to show the current lack of rehabilitation personnel for divisions which are currently available. We suggest that to plan rehabilitation for arthritis or other diseases without an adequate supply of personnel is to build a cast without wheels; it will move very little. Unless some efforts are made

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occupational therapists, and the other similarly personnel. Our experience in Britain, Columbia is perhaps

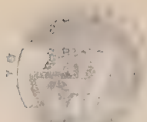
an example in that we have attempted to provide this facility, this rehabilitation facility for the arthritis patients throughout the province at all community levels whereas the experience in many areas of the country and of the continent has been confined to the problem of



1 With respect to the third recommendation  
2 for the need for integration and co-relation of services  
3 throughout the province, we feel that it is desirable  
4 to consider the patient as the centre of the rehabilita-  
5 tion programme so that services available are directed  
6 towards moving him from the rehabilitation process to  
7 his maximum capacity. As presently constituted patients  
8 tend to receive treatment in an acute hospital for acute  
9 stages of the disease, others may have some rehabilita-  
10 tive aspects to it, then if the patient does not have  
11 services available for follow-up the initial gains made  
12 by this treatment may be lost in that the patient returns  
13 to an area where he does not have follow-up treatment  
14 and he will regress to his previous disability.

15 Other ancillary services are available  
16 in this province, welfare societies, placement societies  
17 and so on, but these suffer from lack of integration with  
18 the rehabilitation process. It is the welfare people  
19 being concerned with the provincial government and the  
20 dispensation of their funds and the placement people at  
21 present being part of the Department of Labour, and  
22 perhaps they are better acquainted with the available  
23 jobs than they are with the available skills of the  
24 rehabilitated cases.

25 A number of other useful aides to the  
26 rehabilitation process include the provision of splints  
27 and self-help devices. There is at present no means by  
28 which a patient can obtain these other than through his  
29 direct payment and this, of course, he has been unable  
30 to do or from the provision of these by the Society



With respect to the third recommendation for the need for integration and co-ordination of services throughout the province, we feel that it is desirable to consider the patient as the centre of the rehabilitation programme so that services available are directed towards moving him from the rehabilitation process to the maximum capacity. As previously constituted patients tend to receive treatment in an acute hospital for acute stages of the disease, others may have some rehabilitation aspects to it, and if the patient does not have services available for follow-up and initial gains made by this treatment may be lost in that the patient returns to an acute stage he does not have follow-up treatment and he will regress to his previous disability.

Other auxiliary services are available in this province, welfare societies, placement societies and so on, but these suffer from lack of integration with the rehabilitation process. It is the welfare people being concerned with the provincial government and the dispensation of their funds and the placement people at present being part of the Department of Labour, and perhaps they are better acquainted with the available jobs than they are with the available skills of the

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and self-help devices. There is at present no means by which a patient can obtain these other than through his





1 itself whose ability to provide this sort of service is  
2 necessarily limited, and any plans for an outside  
3 rehabilitation process should take cognizance of these  
4 needs.

5 DR. SLADE: The medical advisory board  
6 of C.A.R.S. believes that the major gap in our facilities  
7 for treatment here in British Columbia is the lack of  
8 an adequate provision for long-term in-patient beds.  
9 Our experience here indicates two types of situations  
10 exist where long-term in-patient bed care is necessary  
11 as a patient with rheumatoid arthritis or spondylitis  
12 who has progressive active disease where serious dis-  
13 abilities occur, and secondly, the patient with those  
14 conditions, rheumatoid arthritis and spondylitis where  
15 continuing or inactive disease has already lowered the  
16 disability and who requires restorative and rehabilita-  
17 tive treatment. For the first group of people with  
18 continued progressive active disease there is no adequate  
19 provision in British Columbia at the moment. It is  
20 recognized that if home and out-patient and acute  
21 hospital care are available most patients can be managed  
22 adequately at one or other of these levels, but some  
23 patients with continuing active disease require acute  
24 hospitalization or continuing rehabilitation therapy  
25 over an extended period of time which would be so,  
26 because severe and lasting disability can result from  
27 deformity developing over a course of one initial  
28 prolonged bout of active disease. In an in-patient unit  
29 of this type is a situation where a medical management,  
30 physiotherapy and education can be all brought together,





1 and this certainly in our experience is the most  
2 effective way of treating these people at this time.

3 Now, in our in-patient facility the  
4 average period of time would be about three months but  
5 there are some who require a much longer period of  
6 treatment. In the second category are more prolonged  
7 disability, at the moment we have fifteen beds available  
8 for this group of patients and here education is as  
9 important as it is with the first group of patients, but  
10 here the intensive restorative programme requires a  
11 different emphasis. Here too we often need surgical  
12 and orthopaedic procedures. Now, at this time there is  
13 quite a backlog of patients particularly in group two  
14 in British Columbia and it would seem that with the  
15 proper facilities that this number of people would  
16 be very markedly reduced. At the moment we have waiting  
17 lists up to people waiting for periods of three months  
18 or more before we can give them help in this way with  
19 this prolonged rehabilitation therapy. We strongly  
20 recommend that facilities for in-patients be provided  
21 and at least forty beds here in the Vancouver area, ten  
22 of these over at the U.B.C. Hospital or where they can  
23 be most useful for research and teaching purposes and  
24 thirty for rehabilitation care in a unit in conjunction  
25 with some general hospital. The location of this unit  
26 is important. The one problem that we have now is  
27 related to the fact that our unit is not close to the  
28 general hospital where there is a difficulty in getting  
29 internes treatment and in a sense exposing them to the  
30 problems of these people. On the one hand, the



and this certainly in our experience is the most effective way of treating these people at this time. Now, in our in-patient facility the average period of time would be about three months but there are some who require a much longer period of treatment. In the second category are more prolonged disability, at the moment we have fifteen beds available for this group of patients and here education is as important as it is with the first group of patients, but here the intensive restorative programme requires a different emphasis. Here too we often need surgical and orthopaedic procedures. Now, at this time there is quite a backlog of patients particularly in group two in British Columbia and it would seem that with the proper facilities that this number of people would be very markedly reduced. At the moment we have waiting lists up to people waiting for periods of three months or more before we can give them help in this way with this prolonged rehabilitation therapy. We strongly recommend that facilities for in-patients be provided and at least forty beds here in the Vancouver area, ten of these could be at the U.B.C. Hospital or where they can be used chiefly for research and teaching purposes and thirty for rehabilitation care in a unit in conjunction with some general hospital. The location of this unit is important. The one problem that we have now is related to the fact that our unit is not close to the general hospital where there is a difficulty in getting intensive treatment and in a sense exposing them to the problems of these people. On the one hand, the



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1 difficulty in arranging adequate post-graduate or  
2 resident education in connection with them and the  
3 tendency also for undue difficulty in bringing practising  
4 physicians in contact with the people who have to be  
5 in the services for this prolonged period. We feel  
6 strongly that these beds are necessary.

7 THE CHAIRMAN: Thank you, Dr. Slade.  
8 Have you anything further?

9 MR. McAVITY: Miss Pack.

10 MISS PACK: Mr. Chairman and members  
11 of the Commission, these recommendations are merely  
12 supplementary to complement and make effective the  
13 previous recommendations. Governmental support for  
14 research in the rheumatic diseases should more nearly  
15 match the need. Over the past five years the National  
16 Health and Welfare Department has contributed \$71,000.00,  
17 \$69,000.00, \$66,000.00, \$32,000.00 and \$100,000.00 to  
18 research in arthritis. Last year the Canadian Arthritis  
19 and Rheumatism Society supplied \$200,000.00 which was  
20 twice as much, and for some one million people with  
21 rheumatic diseases in Canada we think this contribution  
22 should be raised considerably.

23 The Medical Research Council should be  
24 given additional funds and the autonomy which will allow  
25 it to stimulate activity in arthritis research and the  
26 authority to support research studies in this field  
27 both basic and clinical. At present funds from public  
28 general health grants are not used for clinical research.

29 There should be a health care and research  
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1 programme for children with collagen and rheumatic  
2 disease to ensure early expert diagnosis, proper care  
3 and follow-up, continuity of these children's education,  
4 contact with the family, and research. The establishment  
5 of a paediatrician, specialist in rheumatic disease in  
6 children at U.B.C. with assistant and staff would cost  
7 probably \$28,000.00 in funds per annum.

8 Provision should be made under the  
9 B.C.H.I.S. for out-patient treatment of those who can be  
10 transported to the hospital or treatment units and for  
11 home care for those who cannot be transported.

12 The cost of treating the patients at  
13 out-patient and home level should be cheaper than as in-  
14 patients in the long run. However, B.C.H.I.S. should  
15 cover this care under the approved plan suggested by  
16 Mr. Cox at the B.C.H.A. convention in 1961.

17 There should be exchange of ideas between  
18 those who are planning various facets of the province-  
19 wide rehabilitation programme and definite lines of  
20 community set-up.

21 We feel that there is a great fund of  
22 information, knowledge and experience in this field and  
23 pooling these ideas we could develop a truly good  
24 rehabilitation programme for this province if this were  
25 all used.

26 There should be long term planning by  
27 communities to provide balance among diverse elements of  
28 health resources so that provision is made for easy  
29 transfer and disposition of patients from one type of  
30 facility to another and from one level of care to another





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1 as the physician directs.

2 Co-ordinated planning should be part of  
3 the job of the agency, hospital staff and boards. At  
4 present lack of custodial units can clog nursing homes  
5 and prohibit admittance of those needing rehabilitation  
6 care. Hence, lack of beds can prevent these patients  
7 from discharge from general hospitals.

8 There should be proper supervision and  
9 classification of standards and rates of nursing and  
10 boarding homes so that rehabilitation practices may be  
11 continued by patients resident in them and so that costs  
12 to the patient may be fair.

13 That is, the doctor and the patient must  
14 know what type of care they may expect and what they may  
15 expect to pay for.

16 Closer supervision and rating might cost  
17 employemnt of one or two more persons -- \$12,000.00  
18 approximately. The Department of Health and Welfare  
19 could cover. Now, being short of staff, the proper  
20 supervision could be handled similar to that of auto  
21 courts and motels or descriptive rating might help to  
22 distinguish between the types of care.

23 The shortage of expert orthopaedic boot  
24 and brace-makers could be met by training under  
25 rehabilitation grants. The occupational therapists on  
26 our staff use a great amount of time especially with the  
27 patients who have deformed feet in making adjustments  
28 to shoes after purchase. Training in the fitting and  
29 manufacture of shoes for persons with deformities would  
30 be very valuable. There should be developed by hospitals



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1 and sponsored by B.C.H.I.S. the concept and system of  
2 follow through from in-patient to out-patient and home  
3 care. If necessary, provision should be made for take-  
4 home appliances, self-help aides, special drugs, splints  
5 and casts. At present if a person needs a home  
6 appliance, a self-help aide, or a wheel chair, he has  
7 to look around amongst his friends, service clubs or  
8 through the social welfare department if he cannot buy  
9 it for himself.

10 THE CHAIRMAN: Is there no voluntary  
11 organization that has a loan cupboard?

12 MISS PACK: Often these things have to  
13 be specially designed for the person concerned, they  
14 cannot be traded. We have loan cupboards, of course.

15 A community workshop is recommended where  
16 physically disabled persons who cannot be placed in  
17 regular work, may be trained to work or to produce  
18 articles to give them mental stimulus, a source of income,  
19 to keep them active and give them a sense of being use-  
20 ful again. Present deficit to C.A.R.S. is approximately  
21 \$1,095.00 in 1961. If these were expanded to the  
22 community, these costs would be much higher at first but  
23 later would level off and service clubs might under-  
24 write this.

25 The community workshop should embrace:

26 A. A vocational rehabilitation workshop  
27 including medical, social, vocational assessment training  
28 either on the job or at vocational schools.

29 B. Employment under sheltered conditions  
30 for those physically disabled persons who cannot enter



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1 competitive employment.

2 C. The nucleus for planning and dispatch-  
3 ing for vocational programme for home-bound disabled.

4 Persons on social assistance, recommended  
5 by an agency constituted with medical direction as  
6 C.A.R.S. is, should be given medical benefits for a  
7 prescribed period after financial independence is gained.  
8 On the recommendation of the patient's doctor as to the  
9 amount of time he is able to work, the patient should  
10 receive his monthly social assistance up to that amount  
11 and the patient working under controlled work conditions  
12 should be allowed to keep his earning for those hours  
13 which he is able to work.

14 A person who has a recurring illness such  
15 as arthritis is liable to be well for several months or  
16 even years only to have an exacerbation which will prevent  
17 him from continuing to work and medical and para-  
18 medical care will be necessary. If the security of  
19 knowing that his medical coverage will be continued for  
20 a stated time is given he can be more readily encouraged  
21 to make the final effort.

22 The remuneration suggested in the appendix  
23 is merely to suggest the method of encouraging disabled  
24 persons to regain full independence. The present system  
25 is demoralizing and is frustrating to those receiving  
26 social assistance and those working with the disabled.

27 Job placement personnel should work as  
28 part of the rehabilitation team so that plans for getting  
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1 This would mean an additional person or  
2 two to work specifically with agencies and institutions  
3 dealing with the disabled.

4 Section 16 of the National Housing Act  
5 of 1954 should be amended to allow low cost housing now  
6 being authorized for the disabled elderly persons to be  
7 rented to those who are disabled regardless of age.  
8 To estimate the probable cost of this is impossible as  
9 numbers needing this housing are not known but this  
10 project could be started at very little extra cost in  
11 housing units gradually as they are being planned.

12 The rent in these and those which have  
13 been established are \$26.00 for a single unit and \$42.00  
14 for a double unit, but most of the houses fall under the  
15 National Housing Act for those of low income and are  
16 restricted to those over the age of sixty. We would like  
17 to implement this for those who have disabilities.

18 THE CHAIRMAN: Thank you.

19 MR. McAVITY: That, sir, completes our  
20 presentation.

21 COMMISSIONER BALTZAN: I have two  
22 questions that revolve around the same theme. Question  
23 number one, would it be possible to hope to put many  
24 of these crippling diseases under the expanding field  
25 of the rehabilitation programme? Before you answer that  
26 let me say the same question arises in connection with  
27 the diseases concerning arthritis, multiple sclerosis  
28 victims, etcetera. Would it be possible to hope that  
29 these should come under eventually this expanding field  
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1 DR. FAHRNI: Mr. Chairman, Dr. Baltzan,  
2 certainly this ties in with the case load of disabled  
3 people generally in the community. We have every reason  
4 to hope that this would be included as services are  
5 arranged for some of the groups which exist in present  
6 medical coverage in the community that would cover the  
7 rheumatic group of patients.

8 I think it is interesting that this  
9 Society has been able to go as far as it has in providing  
10 medical services, more or less, in both urban and rural  
11 sections of the province. The type of service that has  
12 been supplied there, of course, is the same type of  
13 service. In many cases it is necessary to reactivate  
14 a stroke or fractured femur, getting people on their  
15 feet. Supporting equipment is necessary as a help.

16 COMMISSIONER FIRESTONE: I have no  
17 doubt about the accomplishments of the association. My  
18 question was directed in future towards whether instead  
19 of having so many of these fragmentations going on, we  
20 might eventually expect all these cases or the majority  
21 of these cases would come under this field of  
22 rehabilitation.

23 My question number two, Dr. Cofton, you  
24 refer to intensive research, you refer to research  
25 activities connected with rehabilitation, making  
26 rehabilitation more than the salvaging operation, that is  
27 in the mind of people. That is not true as far as  
28 arthritis is concerned. There is research, indeed;  
29 you stated you wanted forty beds, research, etcetera.  
30 If the question of research generally is applied under

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rehabilitation more than the salvaging operation that is in the mind of people. That is not true as far as orthotics is concerned. There is research, indeed, you stated you wanted forty beds, research, etcetera. If the question of research generally is applied under



1 the rehabilitation programme, would it take it from its  
2 almost present status of a salvage operation?

3 DR. GORTON: Mr. Chairman, Dr. Baltzan,  
4 perhaps I could answer that question by referring  
5 briefly to your first question.

6 In an ideal rehabilitation programme,  
7 if such comes to be, there is no question but that both  
8 the treatment of arthritis and its disabilities and the  
9 research necessary to improve that treatment, and perhaps  
10 to find some fundamental answers to the arthritic  
11 diseases -- that is the ideal situation.

12 What we must deal with at the moment, we  
13 must recognize that the arthritic patient faces certain  
14 problems other chronic illnesses don't pose to anything  
15 like the same degree. Most other types of disabilities  
16 requiring research are static conditions or episodes  
17 in which the disability is imposed by surgery, stroke,  
18 polio, or whatever. In the arthritic patient there is  
19 frequently a continuing disease which requires that  
20 the patient be treated initially and in a continuing  
21 manner by a physician expert in the disease process as  
22 well as by rehabilitation personnel expert in the  
23 rehabilitation process. This is not nearly as marked,  
24 as I say, in the other diseases.

25 We treat rehabilitation of the arthritic  
26 as consisting of three phases, or three aspects, perhaps.  
27 One is preventive rehabilitation which has no other  
28 term, really, and this consists in the supervision of  
29 the acute illness by both the skilled physician and the  
30 skillled rehabilitation personnel to prevent disability.





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skilled rehabilitation personnel to prevent disability.



1 This is probably the most fruitful and most important  
2 aspect of rehabilitation in this disease group, lesser  
3 in the others, obviously.

4 Then, the second stage in arthritic  
5 rehabilitation where disabilities can be corrected and  
6 where disabilities which have begun can be halted and  
7 minimized.

8 The third is that of salvage, and, of  
9 course, is the least fruitful in a sense, and the one  
10 we would emphasize the least.

11 A proper centre where all these personnel  
12 could be brought together and concentrated would lead  
13 not only to improvement of methods and improvement of  
14 treatment, but to the stimulation and education of the  
15 physicians who treat this disease without being either,  
16 at the moment, expert in the management of the disease  
17 process or in rehabilitation. This should allow good  
18 rehabilitation methods to be used at community levels,  
19 not only in specialized centres.

20 COMMISSIONER BALTZAN: Thank you.

21 Just to finish that matter, in connection with the  
22 problem of re-integration of these several things, there  
23 is in the minds of people fragmentation of medicine and  
24 fragmentation of treatment in relation to diseases.  
25 If we could possibly re-integrate it instead of breaking  
26 it up further, it would serve a great deal in the way  
27 of administration and would be conducive to more rapid  
28 progress.

29 DR. GOFTON: I believe that the Society  
30 is in complete accord with that project. It is within



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3 in the others, obviously.

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5 rehabilitation where disabilities can be corrected and

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18 rehabilitation methods to be used on community levels,

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20 COMMISSIONER LAWRENCE: Thank you.

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22 problem of re-integration of these people, there

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24 fragmentation of treatment in relation to disease.

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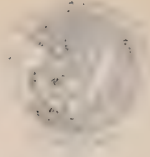
1 our power to improve the treatment for this diseased  
2 group specifically, and these improvements in no way  
3 prevent ultimate integration into other areas which  
4 perhaps will require improvement. Perhaps you would be  
5 interested to know, or perhaps you are aware that  
6 approximately twenty-five per cent of the treatment  
7 services which we provide in the province to our  
8 communities in the province, are directed to non-arthritic  
9 cases so we have in a sense moved somewhat towards  
10 integration within the limits imposed by our funds and  
11 our personnel. Had we more funds and more personnel  
12 we would have tackled more of these and had a more  
13 integrated rehabilitation process or programme than we  
14 have now. It wouldn't be unreasonable to say had the  
15 rehabilitation of other diseases or illnesses kept pace  
16 with the development of treatment for the arthritics in  
17 the province that we would now in these centres have  
18 integrated.

19 On this I would agree with you, but we  
20 are not as a society able to get these other fields as  
21 well as our own.

22 COMMISSIONER BALTZAN: That answers my  
23 question.

24 THE CHAIRMAN: Miss Girard? Dr. Van Wart?

25 COMMISSIONER VAN WART: On section 46,  
26 you speak of the deplorable state or the shortage of  
27 physiotherapists and you go on in 47 to suggest a means  
28 by which you can supplement the training and so on.  
29 The money to carry out these suggestions, do you visualize  
30 it coming from any special source?



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 we would have tackled more of these and had a more  
 integrated rehabilitation program or programs than we  
 have now. It wouldn't be unreasonable to say had the  
 rehabilitation on or other diseases or illnesses kept pace  
 with the development of treatment for a condition in  
 the province that we would now in these centres have  
 integrated.  
 On this I would agree with you, but we  
 are not as a society able to get these other funds as  
 well as our own.  
 question.  
 COMMISSIONER VAN WART: On section 46,  
 You speak of the deplorable state of the shortage of  
 physiotherapists and you go on to suggest a means  
 by which you can supplement the training and so on.  
 The money to carry out these suggestions, do you visualize  
 it coming from any special source?



1 MISS PACK: As far as bursaries are  
2 concerned, Mr. Chairman, the Canadian Arthritis and  
3 Rheumatism Society has offered bursaries each year for  
4 the past three or four years up to five hundred dollars  
5 per student. We have this year received only one request.  
6 I think one of the reasons -- the first A.B.C. in  
7 number 48 are probably the reasons for this. There  
8 haven't been enough students waiting and ready to take  
9 the courses. Those are the parts we are anxious to  
10 promote.

11 COMMISSIONER VAN WART: Are there  
12 limitations attached to the bursaries?

13 MISS PACK: Yes, five hundred dollars.  
14 We have been going up to five hundred dollars expecting  
15 the girl herself to be able to provide some of the funds.  
16 If the girl returns to work for the Canadian Arthritis  
17 and Rheumatism Society her bursary is waived at so much  
18 per month for the time she works for us.

19 THE CHAIRMAN: Anywhere in Canada?

20 MISS PACK: She trains in the University  
21 of B.C. and works in British Columbia.

22 THE CHAIRMAN: You are talking now of  
23 British Columbia?

24 MISS PACK: Since we have had the school  
25 in B.C., yes. Before we educated girls in McGill and  
26 Toronto.

27 THE CHAIRMAN: You brought them back to  
28 British Columbia?

29 MISS PACK: Yes.

30 COMMISSIONER VAN WART: You say only





MISS PARK: As far as burials are

concerned, Mr. Chairman, the Canadian Arthritis and Rheumatism Society has offered burials each year for the past three or four years up to five hundred dollars

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COMMISSIONER VAN WART: And there

limitations attached to the burials?

MISS PARK: Yes, five hundred dollars.

We have been going up to five hundred dollars expending the first hundred to be able to provide some of the funds. If the first returns to work for the Canadian Arthritis and Rheumatism Society for living is valued at an amount per month for the time she works for us.

THE CHAIRMAN: Anywhere in Canada?

MISS PARK: She begins in the University

of B.C. and works in British Columbia.

THE CHAIRMAN: Are you talking now of

British Columbia?

MISS PARK: I hope we have had the school

in B.C., yes. Before we started girls in 1901 and Toronto.

THE CHAIRMAN: You brought them back to

British Columbia?

MISS PARK: Yes.

COMMISSIONER VAN WART: You say only

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1 one bursary is all you have in operation this year?

2 MISS PACK: One in this year's school  
3 at the University of British Columbia. We have four  
4 others out in their second year, completing the year.

5 COMMISSIONER VAN WART: Do you find this  
6 limitation, that they must come back to British Columbia,  
7 detrimental to the number of applications you receive?

8 MISS PACK: Well, I believe every  
9 applicant has been granted a bursary.

10 COMMISSIONER VAN WART: Do you think if  
11 that limitation wasn't there you would have more  
12 applicants?

13 MISS PACK: I don't think so.

14 THE CHAIRMAN: Has anyone ever said I  
15 would like to get a bursary, but I want to be free to go  
16 anywhere else in Canada?

17 MISS PACK: I don't think so.

18 COMMISSIONER McCUTCHEON: They are free  
19 to as long as they pay back the bursary?

20 MISS PACK: As long as they pay it back.

21 DR. GOFTON: I think it would be fair  
22 to say it wouldn't increase substantially the number of  
23 people applying. It wouldn't come anywhere near meeting the  
24 gap which we conceive to be present.

25 COMMISSIONER VAN WART: An active  
26 educational programme, number one, who do you visualize  
27 carrying out that programme?

28 MISS PACK: At present there are no  
29 films or pamphlets except one dealing with this career.  
30 Most of the other careers have films put out either by



one business in all you have in operation this year?

MISS PACE: One in this year's school

at the University of British Columbia. We have four

others out in their second year, completing the year.

COMMISSIONER VAN WART: Do you find this

limitation, that they must come back to British Columbia,

debarment to the number of applications you receive?

MISS PACE: Well, I believe every

applicant has been granted a business.

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that limitation means that there would have more

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MISS PACE: I don't think so.

THE CHAIRMAN: Has anyone ever said I

would like to get a business, but I want to be free to go

anywhere else in Canada?

MISS PACE: I don't think so.

COMMISSIONER WOODWARD: They are free

to as long as they pay back the business?

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Most of the other careers have films out and either by





1 the Department of Health in Ottawa or by the National  
2 Film Board or the Department of Education. We as a  
3 Society would like to see that there is more education  
4 on the careers of physiotherapy and occupational therapy  
5 given to the children so they actually know what  
6 physiotherapy is. Most of them haven't heard the name  
7 until we give it to them.

8 COMMISSIONER VAN WART: Do you think your  
9 organization should put out these films or the departments  
10 of government or who should be responsible for stimulating  
11 the educational programme?

12 MISS PACK: We feel we are doing our  
13 share.

14 COMMISSIONER VAN WART: You recommend  
15 this as a means of overcoming the shortage of physio-  
16 therapists. Do you think it is a part of the government  
17 to carry on this educational programme or do you think  
18 it should be initiated entirely from your national  
19 organization or from what source?

20 MISS PACK: I think every source can  
21 help. We have done a great deal in the educational field,  
22 sending speakers to all the high schools in the province  
23 and circulars to counsellors and teachers and bringing  
24 this before the general public, the P.T.A., and the  
25 young children in British Columbia. We would like to  
26 see this spread throughout the Dominion. I don't think  
27 our Society could undertake that. It would be quite a  
28 job. I can see the Department of Education, the other  
29 organizations utilizing physiotherapy services and the  
30 Department of Health undertaking this, perhaps, jointly.



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26 see this spread throughout the Dominion. I don't think  
27 our Society could undertake that. It would be quite a  
28 job. I can see the Department of Education, the other  
29 organizations utilizing physiotherapy services and the  
30 Department of Health undertaking this program jointly.



1 COMMISSIONER VAN WART: Would it be a  
2 sphere in which the Federal Government should partici-  
3 pate?

4 MISS PACK: Yes, I think so.

5 COMMISSIONER VAN WART: Regarding  
6 expansion, number two, of the research personnel, do you  
7 feel these training schools should take a more active  
8 part in stimulating people to enter the field of  
9 rehabilitation, physiotherapy?

10 MISS PACK: We feel that in view of the  
11 fact that the possible registration in Canadian  
12 universities in 1960 was 754, and only 480 were register-  
13 ed there must be some reason for students not filling  
14 these quotas. We think perhaps the Canadian universities  
15 could do something about it. Our own school started with  
16 nineteen, with possible fifty. We would like to see the  
17 other universities fill the gap and more room made for  
18 students.

19 COMMISSIONER VAN WART: You feel the  
20 universities could carry on a programme to stimulate the  
21 youth to take up physiotherapy?

22 MISS PACK: As long as there is a field  
23 for improvement here, I think it is a shame that people  
24 are not made aware of the possibilities. There are  
25 wonderful opportunities for both boys and girls to take  
26 positions in this field.

27 COMMISSIONER VAN WART: Do you feel the  
28 university authorities are aware of the acuteness of the  
29 shortage of physiotherapists in Canada?

30 MISS PACK: I don't know if they are







1 aware of it. Do you, Dr. Fahrni?

2 DR. FAHRNI: There was a Canadian  
3 conference of physiotherapy held in Toronto in May last  
4 year. All these problems were discussed, the shortage  
5 and the possible means of filling it. There were  
6 universities, representatives of the schools at the  
7 meeting, and I know the proceedings were sent to them.

8 COMMISSIONER VAN WART: That is all,  
9 Mr. Chairman.

10 THE CHAIRMAN: Mr. McAvity and your  
11 associates, Miss Pack, this brief on behalf of those  
12 affected in the Province of British Columbia and in a  
13 more general way on behalf of those affected in Canada,  
14 is one that interests us to a very great extent. There  
15 is one idea that is being suggested, that is of a  
16 comprehensive medical service plan.

17 What does your organization see as the  
18 role, as its role, as the role of voluntary organizations  
19 and of the volunteers, if such a plan should come into  
20 being?

21 DR. SLADE: Mr. Chairman ----

22 THE CHAIRMAN: If all your recommenda-  
23 tions were accepted and the government was going to have  
24 A, B, C, and D, does that mean passing out of existence  
25 of C.A.R.S., and the volunteers in that field?

26 DR. SLADE: Mr. Chairman, we feel that  
27 C.A.R.S. has done a very good job with the facilities  
28 at hand, and the use of voluntary people has many  
29 advantages, not the least of those is the fact that there  
30 are many people with a great variety of interests



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2 DR. BAHM: There was a Canadian

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4 year. All these problems were discussed, the shortage

5 and the possible means of filling it. There were

6 universities, representatives of the schools at the

7 meeting, and I know the proceedings were sent to them.

8 [Faint text, possibly a name or title]

9 THE CHAIRMAN: Mr. McAvity and your

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11 affected in the Province of British Columbia and in a

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29 are many people with a great variety of interests





1 brought together managing such an organization. We feel  
2 that organizations of this type play a very large part  
3 in the development of rehabilitation services in general  
4 throughout the country.

5 And certainly there is a great need for  
6 help and support for any private organization that can  
7 performed duty of this order. This is a very good thing,  
8 if an organization like this can produce results for the  
9 people involved-- the patients. It is a very great  
10 thing for the community, that the community is particu-  
11 larly involved in this sort of activity, and especially  
12 it is a good thing for those volunteers who give their  
13 time and energy to it.

14 THE CHAIRMAN: Your funds come  
15 principally from donations, the Community Chest and so  
16 forth, etcetera; is that a fact?

17 DR. SLADE: And some from the provincial  
18 government, yes.

19 THE CHAIRMAN: Yes, but across Canada,  
20 I take it, the funds are principally from private  
21 donations?

22 DR. SLADE: That is true, yes.

23 THE CHAIRMAN: Have you any opinion to  
24 offer, any view to suggest as to what may be the effect  
25 on private giving if a comprehensive health care service  
26 plan should be brought into being?

27 DR. SLADE: Well, Mr. Chairman, this  
28 would depend on the enthusiasm and devotion of the people  
29 involved in such a scheme. The development of a  
30 comprehensive scheme may affect some people in their



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1 attitudes toward this sort of an organization, but I  
2 feel that it would still have a very major part to play  
3 in the need of the country as a whole.

4 THE CHAIRMAN: I am not talking about  
5 your own volunteer and your own work; I am talking  
6 about the attitude of the public towards giving you the  
7 sinews of war to continue your work?

8 DR. SLADE: Sir, I still feel that --  
9 whereas I can see the point that -----

10 THE CHAIRMAN: I am just wondering. This  
11 is a problem that we would like your views on. It is  
12 a subject upon which we would like your views.

13 DR. SLADE: Fine. Well, we still feel  
14 there is a very large place for voluntary activity.

15 DR. GOFTON: Mr. Chairman, could I  
16 speak to that briefly? The advent of government supported  
17 hospitalization here relieved the people of some of the  
18 burden of sickness and a comprehensive medical service  
19 would undoubtedly further relieve that burden. The  
20 Arthritis Society's experience has been that it is un-  
21 likely that any service will be sufficiently comprehensive  
22 to totally relieve the burden on particularly groups of  
23 disabled people with diseases such as arthritis. I  
24 would anticipate personally that there would remain needs  
25 to be met. It would then devolve upon the organization  
26 concerned to convince the public that these needs were  
27 real, and that real and worthwhile answers were being  
28 provided. I think if this were done, one would have  
29 commensurate support.

30 If, on the other hand, the scheme devised





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It, on the other hand, the scheme devised



1 were such as to ~~cradle from cradle to grave,~~ there would  
2 be no real argument for a voluntary organization to  
3 present to the public for support. There would be no  
4 work for them to do. This is more or less self-evident.

5 I think one would have to work out what  
6 kind of scheme do you envisage, or how complete a  
7 scheme is envisaged before one could give an answer as  
8 to anything left to do or not.

9 DR. SLADE: I think that in England,  
10 Mr. Chairman, where they have a very comprehensive  
11 rehabilitation scheme developing, the Rheumatism Council  
12 there continued its activity and a very successful  
13 programme, but it is chiefly along the lines of research,  
14 but it still is a very active organization.

15 THE CHAIRMAN: Well, that perhaps gives  
16 the answer about as well as it can be obtained for the  
17 moment in the day-to-day operation of C.A.R.S. in  
18 British Columbia. Do you find that your arthritic  
19 people, or those suffering from rheumatism have difficulty  
20 in getting treatment; that is, medical treatment?

21 DR. SLADE: We have already mentioned  
22 that in connection with the need for expanded in-patient  
23 facilities, we have a waiting list going on for about  
24 three months.

25 THE CHAIRMAN: I am talking about treat-  
26 ment by physicians, to the extent that it is necessary.

27 DR. GOFTON: I would doubt that we know  
28 of a single case where a man has been unable to find a  
29 physician to care for him. If you are speaking of  
30 difficulty in getting treatment, that is, attendance of



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27 of a single case where a man has been unable to find a

28 physician to care for him. If you are speaking of

29 difficulty in getting treatment, that is, attendance of





1 a physician, I would say no.

2 THE CHAIRMAN: That is what I had in  
3 mind.

4 DR. GOFTON: There is some difficulty  
5 in having access sometimes to more experienced management,  
6 which would be desirable in many cases.

7 THE CHAIRMAN: Then, in paragraph  
8 (Q) you refer to a provincial drug programme. You  
9 are spending about \$4,500.00 a year with one hundred and  
10 fifty patients.

11 Does that supply the demand? Is there an  
12 unmet demand here for drugs which the patient cannot  
13 afford to purchase on his own account?

14 DR. GOFTON: Mr. Chairman, this is a  
15 difficult question to answer. We only know of those  
16 patients whose physician feels that they need a specific  
17 drug, and on his statement that they are unable to  
18 afford it, we supply the drug. Whether there are a great  
19 number of patients who need drugs but do not get them  
20 because the physician does not know of this, we are not  
21 certain, although we have made every effort to publicize  
22 it.

23 THE CHAIRMAN: The profession has been  
24 alerted to the fact that your organization stands in  
25 the background so that no one will suffer?

26 DR. GOFTON: Oh, yes. That is right.

27 THE CHAIRMAN: Thank you very much, Miss  
28 Pack and gentlemen. This will have our serious  
29 consideration.

30 MR. McAVITY: Thank you.



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THE CHAIRMAN: Thank you very much, Miss

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consideration.



1 THE CHAIRMAN: We now have the sub-  
2 mission of the Family Service Agency of Greater Vancouver.

3  
4 --- EXHIBIT NO. 159: Submission of the  
5 Family Service Agency  
6 of Greater Vancouver.

7 SUBMISSION

8 of the  
9 FAMILY SERVICE AGENCY OF GREATER VANCOUVER

10  
11 APPEARANCES:

12 MRS. A. D. BEIRNES

13 MRS. MARGARET COWPER

14 MRS. DOUGLAS STEWART

15 MRS. J. J. R. CAMPBELL

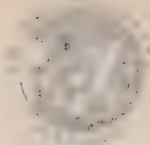
16 MISS BARBARA M. FINLAYSON.

17  
18 THE CHAIRMAN: Mrs. Stewart?

19 MR. STEWART: Yes, sir. Mr. Chairman  
20 and members of the Commission, may I first introduce our  
21 group to you.

22 On my far left is Miss Barbara M. Finlayson,  
23 Director of Casework, Family Service Agency of Greater  
24 Vancouver. Beside her, Mrs. J. J. R. Campbell, Member  
25 of Board of Directors, Family Service Agency of Greater  
26 Vancouver. On my right, Mrs. Margaret Cowper, our  
27 Manager, Supervised Homemaker Service, Family Service  
28 Agency of Greater Vancouver. And next to Mrs. Cowper,  
29 Mrs. A. D. Beirnes, Member of the Supervised Homemaker  
30





THE CHAIRMAN: We now have the app-

Mission of the Family Service Agency of Greater Vancouver

--- EXHIBIT NO. 129: Submission of the Family Service Agency of Greater Vancouver

SUBMISSION

of the

FAMILY SERVICE AGENCY OF GREATER VANCOUVER

ATTENDANCE

MRS. MARGARET GOWDER

MRS. DOUGLAS STEWART

MRS. J. J. R. CAMPBELL

MRS. BARBARA M. THINLEY

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Director of Casework, Family Service Agency of Greater Vancouver. Beside her, Mrs. J. J. R. Campbell, Member of Board of Directors, Family Service Agency of Greater Vancouver. On my right, Mrs. Margaret Gowder, our

Agency of Greater Vancouver. And next to Mrs. Gowder, Mrs. A. D. Bairnes, Member of the Supervised Homemaker



Committee of the Family Service Agency of Greater Vancouver, and President of the Vancouver Council of Women.

Just a word, first, about the Family Service Agency. It is a non-sectarian voluntary agency incorporated under the Societies Act, and it is operated under a constitution by an elected board of directors. For financial support, it is dependent almost entirely upon Community Chest and Councils of Greater Vancouver area as a member of the Canadian Welfare Council and the Family Service Association of America.

Now, our summary.

## SUMMARY

### Conclusions

The family though still a fundamental institution of our culture, is changing in its organization and way of life. These changes have developed the urgent need for services hitherto not required. One of the foremost of these is the need for homemaker service.

Homemaker service is an integral part of any adequate health scheme for Canada, being an economical method of increasing the efficiency of medical teams, and minimizing the need for institutional care.

Population growth and the mobility of families are contributing factors to this change. The increase in the population of children and elderly persons has outgrown the services available to them. Families of today are less deeply rooted in one locality. Relatives, friends and neighbours no longer are as readily available to assist in time of crisis. Another factor is the trend to provide home-care, as opposed



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The family though still a fundamental institution of our culture, is changing in its organization and way of life. These changes have developed the urgent need for services hitherto not required. One of the foremost of these is the need for homemaker service. Homemaker service is an integral part of any adequate health scheme for Canada, being an economic method of increasing the efficiency of medical teams, and minimizing the need for institutional care.

Population growth and the mobility of families are contributing factors to this change. The increase in the population of children and elderly persons has outgrown the services available to them. Families of today are less deeply rooted in one locality. Relatives, friends and neighbours no longer are as readily available to assist in time of crisis. Another factor is the trend to provide home-care, as opposed



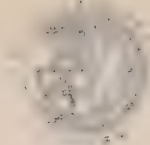


1 to institutional or hospital care, for the aged, the  
2 retarded, the handicapped, the emotionally disturbed,  
3 and the mentally ill. Experiments in this field are  
4 proving the soundness and validity of home-care.

5 Homemaker service helps a family to stay  
6 together in its own home and to preserve the values of  
7 family life. It reduces the potential of emotional  
8 disturbance and mental illness in children and adults  
9 caused by separation from family and familiar environment.  
10 It prevents the expensive consequences of anxiety,  
11 malfunction and illness, both physical and mental,  
12 developing in other members of the family, due to the  
13 disruption caused by the illness of the natural homemaker.  
14 It enables patients to make optimum use of medical  
15 treatment, free of anxiety about family and home.  
16 Provision of homemaker service and social casework as  
17 auxiliaries to the medical treatment, can help in im-  
18 proving family attitudes and factors in the home environ-  
19 ment which contributed to the need for treatment.

20 It reduces the cost of expensive  
21 institutional care, by allowing the patient to return  
22 home earlier. Further hospital expenditures are avoided  
23 when the patient returns to a home strengthened by  
24 homemaker service. It frees hospital and nursing beds  
25 for those who most need them. It reduces the amount of  
26 capital expenditure involved in providing increased bed  
27 facilities in hospitals, nursing homes and institutions.  
28 For a family of three or more children it is less  
29 expensive than foster home care.

30 Homemaker service is a valuable tool in



to institutional or hospital care, for the aged, the retarded, the handicapped, the emotionally disturbed, and the mentally ill. Experiments in this field are proving the soundness and validity of home-care.

Homemaker service helps a family to stay together in its own home and to preserve the values of family life. It reduces the potential of emotional disturbance and mental illness in children and adults caused by separation from family and familiar environment. It prevents the expensive consequences of anxiety, malnutrition and illness, both physical and mental, developing in other members of the family, due to the disruption caused by the illness of the natural homemaker. It enables patients to make optimum use of medical treatment, free of anxiety about family and home. Provision of homemaker service and social casework as auxiliaries to the medical treatment, can help in improving family attitudes and factors in the home environment which contributed to the need for treatment.

It reduces the cost of expensive institutional care, by allowing the patient to return when the patient returns to a home strengthened by homemaker service. It saves hospital and nursing beds for those who most need them. It reduces the amount of capital expenditures involved in providing increased facilities in hospitals, nursing homes and institutions. For a family of three or more children it is less expensive than institutional care.

Homemaker service is a valuable tool in



1 teaching and demonstrating to a family a more adequate  
2 and personally satisfying way of living. It assists and  
3 reinforces the parents' ability to provide adequate care  
4 for their children.

5 It enables the bread-winner to stay on the  
6 job.

7 It provides homemaker employment for women  
8 who have the qualifications as described in the definition.

9 Homemaker service "should be promoted not  
10 as a panacea for all family ills, but as a valuable,  
11 flexible part of a sensible community approach to health  
12 and welfare needs." (Ibid., p. 24)

### 13 Recommendations

14 1. That financial assistance be made available to  
15 provide homemaker service to the people of Canada.  
16 The minimal need is estimated at approximately  
17 one homemaker to every 7000 of population.

18 (See page 11.)

19 2. That services be provided by:

20 (a) expanding existing homemaker programmes;

21 (b) setting up departments within the existing  
22 health and welfare organizations to cover

23 this additional function;

24 (c) encouraging the establishment of new agencies  
25 to provide this service.

26 3. That the Federal Government encourage and support  
27 the provision of training courses for homemakers.

28 4. That provision be made for inclusion of homemaker  
29 service in present and future government sponsored  
30 health insurance schemes.





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11 flexible part of a sensible community approach to health  
12 and welfare needs." (Ibid., p. 24)  
13 Recommendations  
14 1. That financial assistance be made available to  
15 the Ministry of Health and Welfare  
16 The minimal need is estimated at approximately  
17 one homemaker to every 7000 of population.  
18 (See page 11.)  
19 2. That services be provided by:  
20 (a) the Ministry of Health and Welfare  
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22 health and welfare organizations to cover  
23 this additional function;  
24 (c) encouraging the establishment of new agencies  
25 to provide this service.  
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27 the provision of training courses for homemakers.  
28 That provision be made for inclusion of homemaker  
29 service in present and future government sponsored  
30 health insurance schemes.



1 THE CHAIRMAN: Thank you very much, Mrs.  
2 Stewart.

3 Are there any further statements you wish  
4 to make from those who are associated with you here this  
5 morning?

6 MRS. STEWART: No, I think we would be  
7 happy to answer any questions we are able to.

8 COMMISSIONER GIRARD: Mrs. Stewart, I  
9 believe that this Commission is very interested in home-  
10 maker service because of its tie-up with home care. We  
11 have heard a lot of briefs recommending home care.  
12 Therefore, would you tell me how easy or how difficult  
13 it is to recruit homemakers?

14 MRS. STEWART: May I refer this question  
15 to Mrs. Cowper.

16 MRS. COWPER: Our service, as you know,  
17 is limited because of lack of funds, but we did have an  
18 experience in 1949 when a special federal health grant  
19 was made for provision of homemakers' service to families  
20 where the mother or wife was suffering from tuberculosis  
21 and it was necessary for us to increase our staff from  
22 nine to a strength of twenty-nine within a matter of a  
23 few months, and also to provide training for these  
24 people. We had no difficulty in finding recruits for  
25 this service. We found that it is the kind of vocation  
26 that appeals to a great many middle-aged women, and we  
27 feel there are a lot of women with the qualifications  
28 for homemaker work in our community, and it did not  
29 present a problem at that time.

30 COMMISSIONER GIRARD: I gather that

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was made for provision of homemakers' service to families

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feel there are a lot of women with the qualification.

for home-maker work in our community, and it did not

present a problem at that time.

COMMISSIONER GIBBARD: I gather that





1 there would be a lot of women free to take it on a part-  
2 time basis, but you do need homemakers sometimes on  
3 twelve hour or twenty-four hour basis?

4 MRS. COWPER: That is right.

5 COMMISSIONER GIRARD: Are these easy to  
6 find, also?

7 MRS. COWPER: I think that possibly if  
8 you had a large staff you might have to have some who  
9 were unable, because of home responsibilities, to go out  
10 on a twenty-four hour placement. But I think there are  
11 a great many women around the age where it seems the  
12 homemaker service appeals to them as a vocation whose  
13 families are grown up and away, and they are free to take  
14 on a twenty-four hour work. I might add in our agency,  
15 although we only have a small homemaker staff, we have  
16 had many years of experience, and we have found that by  
17 and large families could manage just with day help.  
18 There are some situations where they do require twenty-  
19 four hour service, but that the majority of situations  
20 do not.

21 COMMISSIONER GIRARD: And where do you  
22 get your grants from for homemakers' service?

23 MRS. COWPER: Our grants?

24 COMMISSIONER GIRARD: You do get grants  
25 or financial assistance?

26 MRS. COWPER: Our main source of income  
27 is from the Community Chest.

28 COMMISSIONER GIRARD: The Community Chest?

29 MRS. COWPER: Yes.

30 COMMISSIONER GIRARD: I see on page 11

there would be a lot of money from the sale of the property.

MRS. GOWAN: Well, it might.

COMMISSIONER GIBB: Are these easy to

find, also?

MRS. GOWAN: I think that possibly if

you had a large staff you might have to have some who

were unable, because of their responsibilities, to go out

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MRS. GOWAN: Yes.

COMMISSIONER GIBB: I see on page 11



1 that you say in Ontario the homemaker service is avail-  
2 able to only forty-four per cent of the population, and  
3 you say, "only". I am under the impression that that  
4 is maybe larger than in other provinces. Is this right,  
5 or is this a low percentage?

6 MRS. COWPER: Actually, it is not, Miss  
7 Girard. According to the table on page 7 -- when I say  
8 "only", it is because I am of the conviction that home-  
9 makers' service should be available to one hundred per  
10 cent of the population.

11 COMMISSIONER GIRARD: I am of that  
12 conviction, too, and I know there is a lot of provinces,  
13 or I see here there are a lot, just as I thought, many  
14 provinces under that forty-four per cent.

15 MRS. COWPER: That is right.

16 THE CHAIRMAN: In Ontario, you mentioned  
17 that because of the legislation that permits municipalities  
18 to contribute towards it and the provincial government  
19 contributing fifty per cent up to four dollars a day?

20 MRS. COWPER: That is right, and I did  
21 mention in the brief that the figures I am quoting were  
22 the results of this survey in 1958, and no doubt now  
23 there is an increase over this amount in Ontario, but I  
24 do not have any more available figures than the 1958.

25 THE CHAIRMAN: Have you any comparable  
26 legislation in British Columbia?

27 MRS. COWPER: No, sir.

28 COMMISSIONER McCUTCHEON: One question  
29 on the table on page 7. You show as of 1958 one homemaker  
30 per 6,648 persons in Ontario. That is only in relation





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able to only forty-four per cent of the population, and  
you say, "only". I am under the impression that that  
is maybe larger than in other provinces. Is this right,  
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MRS. GOWEN: Actually, it is not, Miss  
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"only", it is because I am of the conviction that home-  
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cent of the population.

COMMISSIONER GIBBERD: I am of that  
conviction, too, and I know there is a lot of provinces,  
or I see how there are a lot, just as I thought, many  
provinces under that forty-four per cent.

MRS. GOWEN: That is right.  
THE CHAIRMAN: In Ontario, you mentioned

that because of the legislation that permits municipalities  
to contribute towards it and the provincial government  
contributing fifty per cent up to forty dollars a day?

mention in the list that the figures I am giving were  
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there is an increase over this amount in Ontario, but I  
do not have any more available figures than the 1958.

THE CHAIRMAN: Have you a comparable  
registration in British Columbia?

COMMISSIONER MCDONALD: One question  
on the table on page 7. You show as of 1958 one homemaker  
per 6,640 persons in Ontario. That is only in relation



1 to the area in which they operate?

2 MRS. COWPER: That is right.

3 COMMISSIONER McCUTCHEON: It does not  
4 refer to the total provincial population?

5 MRS. COWPER: That is my understanding.

6 COMMISSIONER McCUTCHEON: But in the  
7 area in which they operate, that is an adequate number of  
8 homemakers according to your own brief?

9 MRS. COWPER: Well, it is very difficult  
10 because there has not been any established figure for an  
11 adequate amount, so it is hard to actually say what in  
12 the long run is the adequate amount. But we suggest this  
13 as a starting point, with the suggestion that as further  
14 need is indicated that the service be increased.

CH/J 15 COMMISSIONER GIRARD: You say that the  
16 federal government should encourage and support a train-  
17 ing course for homemakers. How or where would you say  
18 this training course should be given or how would it be  
19 organized?

20 MRS. STEWART: I suppose once again Mrs.  
21 Cowper is the one to answer.

22 COMMISSIONER GIRARD: You do have some  
23 training courses now?

24 MRS. COWPER: We do not have a formal  
25 one, we have an informal training course for our homemakers.

26 COMMISSIONER GIRARD: What do you have  
27 in mind in recommending these formal training courses?  
28 Where would they be given or by whom or how long?

29 MRS. STEWART: In a technical school.  
30 For instance, we would like to establish one here at the



to the area in which they operate

MR. COOPER: That is right.

It does not

MRS. COOPER: That is very understandable.

homework according to your own staff?

MRS. COOPER: Well, it is very difficult

because there has not been any established time for an

assigned amount, so it is hard to actually say what in

the long run is the correct amount. But we suggest this

as a starting point, with the suggestion that as further

work is indicated that the service be increased.

COMMISSIONER: You say that the

federal government should encourage and support a train-

ing course for home science - how or where would you say

this training should be given or how would it be

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COMMISSIONER: What do you have

in mind in recommending these formal training courses?

Where would they be given or by whom or how long?

MRS. STEWART: In a technical school.

For instance, we would like to establish one here at the





1 Vancouver Technical School and we have gone so far as to  
2 approach the school. It is quite possible, they are  
3 quite agreeable provided we demonstrate the need. We know  
4 the need but we must guarantee that there will be a  
5 sufficient number of people to take the course and also  
6 full employment or as full as possible afterwards. We  
7 can get guaranteed employment afterwards but the one  
8 thing that is holding us up is lack of funds.

9 COMMISSIONER GIRARD: I wonder if you  
10 could not get some funds for this as a pilot project  
11 because there are no formal courses now given any place  
12 for the training of homemakers and this is a very valuable  
13 contribution to the health and welfare of the people.  
14 Have you ever tried to get some funds for a pilot project?

15 MRS. COWPER: No. I might add that  
16 there are some formal training programmes for homemakers  
17 in Canada, there is an association in Toronto.

18 COMMISSIONER GIRARD: Mothercraft in  
19 Toronto?

20 MRS. COWPER: They have an arrangement  
21 with the University at Toronto where they provide formal  
22 training for their homemaker staff. Of course, their  
23 staff is so much larger, they are able to do this.

24 MRS. BEIRNES: It is not the difficulty  
25 in obtaining homemakers or people to train, it is the  
26 difficulty of having agencies with enough money to  
27 employ them to fill the needs for homemakers.

28 COMMISSIONER GIRARD: After you train  
29 them?

30 MRS. BEIRNES: Yes, this is the crux of

University Technical School and we have gone as far as to  
 approach the school. It is quite possible, they are  
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 because there are no formal courses now given any place  
 for the training of homemakers and this is a very valuable  
 contribution to the health and welfare of the people.

Are you ever tried to get some funds for a pilot project  
 in the past?

There are some formal training courses for homemakers  
 in Canada, some in association with Toronto.

COMMISSIONER GIBBARD: Informally in

with the University of Toronto where they provide formal  
 training for their home economics students, of course, train-

ing is no doubt a very important thing to do this.

It is not a difficulty to do this.

Optimistic, it is a matter of people to train. It is the  
 difficulty of having agencies with enough money to

employ men to fill the need for homemakers.

them?

MRS. HILLMAN: Yes, this is the work of



1 the problem that there is not enough money to support the  
2 needs of the agencies.

3 COMMISSIONER GIRARD: And I take it for  
4 granted that very few individuals pay for this, the fee  
5 is very small or you do not have people that are paying  
6 for it.

7 MRS. STEWART: We encourage payment and  
8 certainly accept it but it is a very, very small percen-  
9 tage.

10 COMMISSIONER GIRARD: The agency has to  
11 make up the difference?

12 MRS. STEWART: That is right, and also  
13 we have tried very hard, this homemaker committee, to  
14 try to get funds for the other agencies who are served  
15 by these homemakers under the Family Service Agency and  
16 you explain they are used not only for F.S.A.'s casework,  
17 they are used extensively, well as extensively as nine  
18 homemakers can be used, for C.A.R.S., for mental health,  
19 for Children's Aid. Now, these agencies have no funds  
20 to buy this service and we have tried, we have been  
21 endeavouring to get government funds in order to purchase  
22 these services.

23 COMMISSIONER GIRARD: Well, this would  
24 be the same when you say you would like to get them, to  
25 develop them in the department of the existing health  
26 and welfare organizations and those departments would not  
27 have money for this service?

28 MRS. STEWART: Yes, the City Social  
29 Service does pay us.

30 MRS. COWPER: For those people in receipt





the problem that there is not enough money to support the  
needs of the agencies.

4. I would also very much like to pay for this, the fee  
is very small and you do not have people that are paying  
for it.

5. STEWART: We encourage payments and  
certainly accept it but it is a very, very small person-

6. COMMUNITARIAN: I am not sure that  
make us the difference?

7. STEWART: That is right, and also

8. We have tried very hard, this home care committee, to  
now to get funds for the other agencies who are served  
by these home care units of the Family Service Agency and  
you explain that and used not only for P.S.A. but also for  
they are used for various things, well as extensively as this  
home care can be used, for G.A.H.S., for mental health,  
for children's work, for these agencies have no funds  
to buy this service and we have tried, we have seen

9. and we are not getting any more funds in order to purchase

10. COMMUNITARIAN: Well, this would

11. be the same when you say you would like to pay them, to

12. develop them in the development of the existing health  
and welfare organizations and these departments would not

13. have money for this service?

14. STEWART: Yes, the City would

15. service does pay us.

16. MRS. COMPTON: For those people in need?



1 of social assistance, if they need a homemaker they would  
2 reimburse us for the full cost but only if these people  
3 are already on assistance. Last year the fees that were  
4 collected were ten per cent of the cost of the homemaker  
5 service and of that ten per cent three-quarters of it  
6 was paid by agencies which is merely the city's Social  
7 Service Department and only one-quarter of the ten per  
8 cent was paid by clients for the service.

9 COMMISSIONER GIRARD: And the other  
10 ninety per cent was borne by?

11 MRS. COWPER: The Community Chest.

12 COMMISSIONER GIRARD: Thank you.

13 COMMISSIONER BALTZAN: Ladies, thank you  
14 very much for the information that you have given us.  
15 I have learned a great deal from you but I have not any  
16 questions, thank you.

17 COMMISSIONER VAN WART: On page 5 of  
18 your recommendations, number 4:

19 "That provision be made for inclusion of  
20 homemaker service in present and future  
21 government sponsored health insurance  
22 schemes."

23 Do you know of any insurance scheme which  
24 includes homemaker services?

25 MRS. STEWART: In this country?

26 COMMISSIONER VAN WART: Anywhere?

27 MRS. STEWART: I would suspect -- does  
28 anyone know more than I do about it because I would  
29 suspect it is part of the health insurance scheme on the  
30 continent. In several places it has been used extensively,



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continent. In several places it has been used extensively





1 in Holland particularly and in England.

2 MRS. COWPER: Homemaker services in  
3 England is part of the National Health Scheme which came  
4 into being at the time the National Health Scheme was  
5 initiated.

6 COMMISSIONER McCUTCHEON: Your appendix  
7 1, page 3 states Holland, workers have homemaker service  
8 insurance.

9 COMMISSIONER VAN WART: Your idea was  
10 to have it just the same as medical service, drugs,  
11 dental services and so on, the same idea?

12 MRS. BEIRNES: That is right.

13 COMMISSIONER STRACHAN: My question  
14 pertained to the training course and it has been answered.

15 THE CHAIRMAN: Thank you very much, Mrs.  
16 Stewart. This matter of the homemaker service is another  
17 important aspect of health services and we have had  
18 representations as to its importance in every province  
19 in which we have been.

20 MRS. STEWART: I hope we have not  
21 contradicted each other.

22 THE CHAIRMAN: Oh, no. This information  
23 has been supplementary and it does give us the local  
24 picture in each province and the necessity for it and how  
25 much it can save in other services. Thank you very much.

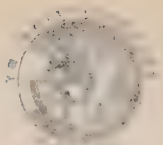
26 We will now recess until two o'clock.

27

28 --- Luncheon recess

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30



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--- Upon resuming.

THE CHAIRMAN: We will now proceed with the submission of the Vancouver Branch of the National Health Federation.

THE SECRETARY: Exhibit 160, sir.

--- EXHIBIT NO. 1960: Submission of the Vancouver Branch of the National Health Federation.

SUBMISSION

of the

VANCOUVER BRANCH OF THE NATIONAL HEALTH FEDERATION

APPEARANCES:

- MR. R. J. LONG
- MR. J. B. HARRISON
- MR. L. GREENALL

MR. LONG: My lord, Mr. Chairman, I would read the summary of the brief as at page 1.

CONCLUSIONS AND RECOMMENDATIONS

SYNOPSIS of the conclusions and recommendations of the submission of the Vancouver Branch of the National Health Federation.

1. Any existing, or future, health insurance scheme should make provisions for the inclusion of all physicians of the healing arts.





--- Upon receiving.

THE CHAIRMAN: We will now proceed with the submission of the Vancouver Branch of the National Health Federation.

--- EXHIBIT NO. 1960: Submission of the Vancouver Branch of the National Health Federation.

SUBMISSION

of the

VANCOUVER BRANCH OF THE NATIONAL HEALTH FEDERATION

MR. R. J. LOMB

MR. J. E. HARRISON

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CONCLUSIONS AND RECOMMENDATIONS

ations of the submission of the Vancouver Branch of the National Health Federation.

1. Any existing, or future, health insurance scheme

should make provision for the inclusion of all

physicians of the healing arts.



2. All qualified physicians (Medical, Osteopathic, Naturopathic, Chiropractic, etc.) be permitted to use public hospitals, as in some European countries.
3. Licensing of all physicians should be handled by a government agency and not by any medical association.
4. Governments should provide fluorides to those who desire them, free of charge in pill or some other form to be administered individually and not compulsorily or indiscriminately.
5. We agree with those doctors who believe that poor health is a direct result of improper living habits and that the positive approach to good health is to educate people to correct these habits.
6. More co-operation between the various healing arts is necessary to correlate these findings and make this knowledge available to the general public.
7. This could be accomplished by government initiative, possibly by the establishment of a research committee comprised of members of all branches of the healing arts.
8. Many, if not all, of these suggestions are already in effect in many European countries and is, in our opinion, the reason for their higher standard of health.
9. Elimination of all forms of tobacco advertising, as was recently done in Italy; to lower public, hospitalization, social services, and employee time loss costs.

Unfortunately, Mr. Chairman, our secretary who has done much of the research in support of our



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1 brief is marooned in South Pender and unable to be  
2 present due to a reoccurrence of a trouble from an old  
3 injury. She is our president and our secretary as well.  
4 We would like to have the privilege of having any  
5 questions that you or the members of your Commission  
6 may have and submit answers to them at a later date since  
7 we lack documentation other than that contained in the  
8 brief.

9 THE CHAIRMAN: Yes, Mr. Long. Mr. Long,  
10 is the idea the questions will be sent forward in  
11 writing to be answered?

12 MR. LONG: Pardon me, your suggestion,  
13 Mr. Chairman, that if any of the panel have questions  
14 relating to our brief that possibly our secretary could  
15 be supplied with them in writing and we can furnish the  
16 answers in writing while your Commission is still sitting  
17 or by some date to be suggested by yourself.

18 THE CHAIRMAN: Very well, any members  
19 who wish to put questions?

20 COMMISSIONER STRACHAN: I feel compelled  
21 to ask one question regarding paragraph 4 with reference  
22 to fluoridation. I think it is a recognized fact, at  
23 least all recognized authorities recognize that communal,  
24 fluoridation of communal water supply is the most  
25 efficient method and possibly one of our greatest hopes  
26 of reducing dental caries and extending to generations  
27 benefit, to the extent of sixty per cent. I wonder why  
28 you would suggest such an inefficient manner as this.  
29 You apparently recognize the value.

30 MR. LONG: Sir, I think our brief covers



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Mr. Lott: Yes, I think our brief covers



1 many points in regard to your question which is certainly  
2 in order. We feel that this matter is still very much  
3 in the controversial stage, even though a considerable  
4 volume of material can be made available for either points  
5 of view.

6 For example, Dr. Exner of the University  
7 of Washington, a former professor of radiology has made  
8 a study since retiring from the faculty extending over  
9 the past seven or eight years and offered a number of  
10 papers and one bound book of considerable size in  
11 collaboration with a gentleman called Waldbot. I suggest  
12 that there is very much corroboration and documentation  
13 that unbalanced fluoridation is not in the public  
14 interests. There are others also. The gentleman on my  
15 left is more qualified to deal with this matter than  
16 myself. There are a considerable number of points in the  
17 brief which constitute a partial answer to your question.

18 I might also say that Dr. Mawhinnie, who  
19 is the past president of the Washington State Dental  
20 Association, and I believe very much a student, has  
21 stated on many occasions that he is just as much against  
22 it now as he was for it a few years back when he knew less  
23 about it. He speaks in very strong terms.

24 COMMISSIONER STRACHAN: I recognize  
25 the fact that there are individuals who are against it,  
26 but I think all recognized authorities and substantiated  
27 authorities support fluoridation of communal water  
28 supplies.

29 THE CHAIRMAN: Did you wish one of your  
30 associates to further answer that question?





many points in regard to your question which is certainly in order. We feel that this matter is still very much in the controversial stage, even though a considerable volume of material can be made available for either point of view.

For example, Dr. Huxley of the University of Washington, a former professor of pathology has made a study since retiring from the faculty extending over the past seven or eight years and offered a number of papers and one bound book of considerable size in collaboration with a gentleman called Walbot. I suggest that there is very much cooperation and documentation that advanced literature is not in the public interest. There are others also. The gentleman on my left is well qualified to deal with this matter than myself. There are a considerable number of points in the paper which constitute a partial answer to your question. I might also say that Dr. Mawhinney, who is the past president of the Washington State Dental Association, and I believe very much a student, has stated on many occasions that he is just as much against it now as he was in a few years back when he knew less about it. He speaks in very strong terms.

COMMISSIONER: I recognize the fact that there are individuals who are against it, but I think all recognized authorities are substantiated authorities support the prohibition of communal water.

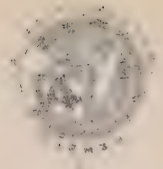
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1 MR. GREENALL: There are two points here,  
2 one I would like to bring your attention to is an  
3 article that appeared in the Vancouver Sun of February  
4 14th, last week. I think probably most of the people  
5 here are familiar with it. A three-year old died in  
6 the dentist's chair. In the reporting of that, we accept  
7 this to be true, that that young three-year old is  
8 reported to have had fluorine added as a supplement to  
9 his diet since birth and he had eleven cavities and two  
10 extractions. If fluorine is the answer to dental caries  
11 there is much explaining to do. I would like to ask this  
12 question in support of this information that is in here.  
13 I have a pamphlet here by the Canadian Dental Association  
14 entitled "Facts". At the end of the pamphlet there is  
15 an article entitled, 'A question, would it be better to  
16 have fluoride tablets. The answer is the best dosage in  
17 this form is not known, people might take either too  
18 much or too little. They say the recommended dosage is  
19 one milligram of fluorine per day per person. If they  
20 cannot put one milligram in a tablet and each child or  
21 individual take one tablet per day, if they put it in  
22 the water supply where some children don't drink water  
23 and some will literally drink it by gallons, they are  
24 bound to get the right amount?

25 COMMISSIONER STRACHAN: I am sorry, I  
26 am not in a position to answer a question inasmuch as  
27 you are not in a position to ask one.

28 MR. GREENALL: I would still like to  
29 ask that question. How is it possible for a child that  
30 doesn't drink water, drinks probably fruit juice ----



MR. GREENHILL: There are two points here,

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1 THE CHAIRMAN: Mr. Greenall, you cannot  
2 put a question. This is not a debating forum. We are  
3 looking for information. It is not our purpose to  
4 educate those who come before us or to change their  
5 opinions. We accept such opinions as they offer. We will  
6 give consideration to the views that are put forward.  
7 I think that is as far as we can go. We have no educative  
8 process to perform. If you must have that question  
9 answered, then you will have to have it answered through  
10 some one who is competent or has a duty to do so.

11 MR. GREENALL: I think I am competent  
12 to do simple mathematics and answer it.

13 THE CHAIRMAN: If you don't want an  
14 answer, if you have the answer, don't get into an argument.

15 MR. GREENALL: I don't think he has  
16 answered.

17 THE CHAIRMAN: It is immaterial whether  
18 he has answered or not. It is irrelevant. We are not  
19 going to get into that discussion any more than we are  
20 going to get into a discussion about the values of a  
21 cure for cancer or bald heads or all the rest of it. It  
22 might be wonderful if somebody might tell me how to grow  
23 hair on my forehead.

24 I would like to know something of your  
25 organization, the National Health Federation. You say  
26 your headquarters are in San Francisco.

27 MR. LONG: That is correct.

28 THE CHAIRMAN: How many members have  
29 you in Canada?

30 MR. LONG: We number a little under



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1 one hundred at the present time, but we are embryonic  
2 at the present time.

3 THE CHAIRMAN: That is what you have in  
4 Canada, about one hundred members?

5 MR. LONG: Yes, I believe so.

6 THE CHAIRMAN: Any membership outside  
7 the province of British Columbia?

8 MR. LONG: Actually no, not as yet, I  
9 don't believe.

10 THE CHAIRMAN: Thank you very much.  
11 When organizations make representations we are naturally  
12 concerned with how many people they purport to be  
13 speaking for.

14 MR. LONG: Surely. I might mention in  
15 the U.S., where the organization is older, though still  
16 young, they have approximately twelve thousand.

17 THE CHAIRMAN: Your brief says ten  
18 thousand.

19 MR. GREENALL: In excess of ten thousand.

20 THE CHAIRMAN: It now has membership  
21 of over ten thousand from all walks of life is the  
22 statement in your brief.

23 MR. LONG: Yes. Incidentally that  
24 includes members of the medical profession, dental  
25 profession and osteopaths and so on.

26 COMMISSIONER BALTZAN: Where did you get,  
27 where can we get the information, you say statistics  
28 show that the standards of health in Canada is very low.

29 MR. LONG: Can you tell me which page  
30 you are referring to?





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you are referring to?



1 COMMISSIONER BALTZAN: Page 3, section  
2 II, under Prevention of Disease. Can you supply this.  
3 You don't have to give it now. You can give it to us  
4 later.

5 MR. LONG: I don't think I have to go  
6 too far in regard to that, Mr. Chairman and sir. The  
7 material can be supplied. I could mention two or three  
8 points. Unfortunately, perhaps, I have to mention the  
9 American parallels, but I think you will agree statistics  
10 in the U.S. in general, and particularly in the northern  
11 and central states have much the same statistics as we  
12 do ourselves. We have, for example, a statement of Dr.  
13 Exner of Washington State who said and has been quoted  
14 in an article a year and a half ago, that the average  
15 American teenager is not as well nourished as a native  
16 of South East Asia, a depressed area of South East Asia.  
17 I am thinking in terms of certain soft-drinks, potato  
18 chips, cornflakes.

19 COMMISSIONER BALTZAN: Excuse me, sir,  
20 I didn't ask for a lecture. Would you be good enough to  
21 supply statistical data at your convenience in time for  
22 us to make reference to your statement?

23 MR. LONG: Yes, I will.

24 THE CHAIRMAN: Thank you, gentlemen.

25 The Pharmaceutical Association of the  
26 Province of British Columbia. It will be submission No.  
27 161.

28  
29 --- EXHIBIT NO. 161: Submission of the  
30 Pharmaceutical Association of the Province of  
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SUBMISSION

of the

PHARMACEUTICAL ASSOCIATION

OF THE PROVINCE OF BRITISH COLUMBIA

APPEARANCES:

MR. G. G. HENDERSON

MR. A. S. BROOKS

MR. D. J. F. BROWN

MR. D. A. DENHOLM

MR. B. STRAIGHT

DR. A. W. MATTHEWS

MR. H. HOLLINRAKE--

THE CHAIRMAN: Mr. Denholm.

MR. DENHOLM: Mr. Chairman, members of the Commission, my name is Douglas Denholm. I am registrar of the Pharmaceutical Association of British Columbia and have been instructed by the president to present this submission to you on behalf of the pharmacists of British Columbia. I have been asked by the president to express his regrets to you today. His name is W. E. Donaldson. He lives in Revelstoke and was unable to come down here.

Accompanying me today and with a view to assisting the Commission in questioning I have with me, on my left, Mr. Douglas Brown, the vice-president of the Association and a practising retail pharmacist; Mr. Alan Brooks, a hospital pharmacist and immediate past president of the B.C. Branch of the Canadian Association



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MR. G. C. HENDERSON

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MR. I. J. F. BROWN

MR. D. A. DEBOLM

MR. E. S. SHERIDAN

MR. DEBOLM: Mr. Chairman, members of

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1 of Hospital Pharmacists; and Mr. G. G. Henderson,  
2 the Association's executive secretary. On my right,  
3 Mr. Byron Straight, the Association's consulting actuary;  
4 Dr. A. W. Mathews, Dean of the Pharmaceutical Faculty  
5 of the University; and Mr. H. Hollinrake, the  
6 Association's legal counsel. May the submission be  
7 presented seated?

8 THE CHAIRMAN: Yes.

9 MR. DENHOLM: Mr. Chairman, Miss  
10 Girard, gentlemen, the brief which has been submitted  
11 to you in writing was drawn by the Committee of the  
12 Association under the supervision of the Council and  
13 with the close co-operation of the Faculty of Pharmacy  
14 at the University of British Columbia. The Faculty  
15 and Dean Matthews were largely responsible for that  
16 section of the brief, particularly dealing with  
17 personnel training and recruitment.

18 As requested in the Commission's direction  
19 on submissions, we have here a summary of the brief which  
20 is divided into nine sections, the introduction, the  
21 statement of policy and also seven divisions by number.  
22 We follow the same pattern in the summary, sir, with one  
23 exception, the last part, seven, conclusions and  
24 recommendations are included in the summary in their  
25 entirety. The summary is as follows:

26 INTRODUCTION

27 We are pleased to have the opportunity  
28 of presenting this submission and hope it will be of  
29 assistance to the Commission.

30 We would point out that the Pharmaceutical





of Hospital Pharmacists; and Mr. G. G. Henderson,  
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 Association's secretary.

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We are pleased to have the opportunity  
 of presenting this submission and hope it will be of  
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 We would point out that the Pharmaceutical



1 Association of the Province of British Columbia is the  
2 statutory licensing and disciplinary body of Pharmacy  
3 in the province in addition to performing a representa-  
4 tive function on behalf of practising pharmacists in  
5 non-statutory matters such as relations with the other  
6 health professions, liaison with various departments of  
7 the provincial government, affiliation with the Canadian  
8 Pharmaceutical Association and so on.

9 Several members of the Association are  
10 assisting in the preparation of the brief which will be  
11 presented to you by the Canadian Pharmaceutical  
12 Association and we are pleased to associate ourselves with  
13 it.

14 THE CHAIRMAN: That is one which will  
15 be presented at Toronto?

16 MR. DENHOLM: Yes, sir.

17 We are disappointed that no pharmacist  
18 was appointed to the Commission and are disturbed to  
19 note there has been no appointment of a Pharmaceutical  
20 Consultant to the Commission. We respectfully request  
21 that the Commission make such an appointment.

22 We are prepared to further assist the  
23 Commission by making a supplementary and/or rebuttal  
24 submission at a future hearing if deemed necessary.  
25

26 STATEMENT OF POLICY

27 Before dealing specifically with matters  
28 within the Commission's Terms of Reference we wish to  
29 outline six general principles held by the Association  
30 to be requisite to a health care program, government



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STATEMENT OF PRINCIPLES

Before dealing specifically with matters  
within the Commission's Terms of Reference we wish to  
outline six general principles held by the Association  
to be requisite to a health care program, government





1 supported or otherwise:

2 1. That it be voluntary.

3 2. That in order to be considered comprehensive  
4 it must include drugs and pharmaceutical  
5 services as a benefit.

6 3. That patients participating must be afforded  
7 complete freedom of choice of pharmacist from  
8 whom benefits are received.

9 4. That there be no restriction on the range of  
10 prescribed drugs.

11 5. That there be an element of patient participa-  
12 tion in the cost of each prescription.

13 6. That the plan be administered by an independent  
14 body largely representative of the professions  
15 providing the services.

16

17 PART I - DRUG DISTRIBUTION IN BRITISH COLUMBIA

18 Drugs are distributed in British Columbia  
19 through the following avenues:

20 1. Licensed retail pharmacies.

21 2. Hospitals.

22 3. Provincial government institutions.

23 4. Provincial government dispensary.

24 5. Service societies.

25 6. Federal government institutions.

26

27 PART II - THE COST OF DRUG DISTRIBUTION IN BRITISH COLUMBIA

28 The cost of drugs to the people in British  
29 Columbia in 1960 (excluding those distributed through  
30 federal government institutions such as Department of



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PART II - THE COST OF DRUG DISTRIBUTION IN BRITISH COLUMBIA

The cost of drugs to the people in British

Columbia in 1960 (excluding those distributed through

federal government institutions such as Department of



1 Veterans' Affairs and Department of Indian Affairs  
2 hospitals) was \$18,250,752.00, of which \$14,840,000.00  
3 was through retail pharmacies. The per capita cost of  
4 drugs in British Columbia in 1960, therefore, was \$11.36  
5 of which \$9.24 was expended in retail pharmacies.

6 The apparent proportion of drugs distributed  
7 through retail pharmacies (81.3%) is inaccurate in terms  
8 of actual drug volume, due to the fact that hospitals  
9 and government institutions purchase many drugs at a  
10 very much lower price than that paid for the same drugs  
11 by retail pharmacists, and also to the fact that  
12 hospital and government purchases of drugs are not  
13 subject to the federal 11% sales tax.

14 The fact that an increasing amount of  
15 money is being spent on drugs is a measure of increasing  
16 utilization of drugs by prescribers rather than a measure  
17 of increasing drug costs, per se. Utilization of drugs  
18 in Canada, in terms of numbers of prescriptions filled,  
19 increased by 1960 to a level of 240% of the 1940  
20 prescription use rate.

21  
22 PART III - FUTURE EXPANSION OF PHARMACEUTICAL SERVICES

23 We advocate the institution of a voluntary  
24 health care program, to include drug benefits in its  
25 first stage and embracing the following principles:

26 1. Prepayment through an independent board largely  
27 representative of the professions providing the  
28 service.

29 2. Participants' freedom of choice of pharmacist.

30 3. Prescribers' freedom of choice of drug(s) but





Veterans' Affairs and Department of Indian Affairs

hospital) was \$18,550,752.00, of which \$15,840,000.00

was through retail pharmacies. The per capita cost of

drugs in British Columbia in 1960, therefore, was \$11.36

of which 19.24 was expended in retail pharmacies.

The apparent proportion of drug distribution

through retail pharmacies (61.3%) is inaccurate in terms

of actual drug volume, due to the fact that hospitals

and government institutions purchase many drugs at a

very much lower price than that paid for the same drugs

by retail pharmacies, and also to the fact that

hospital and government purchases of drugs are not

subject to the federal 15% sales tax.

The fact that an increasing amount of

money is being spent on drugs is a measure of increasing

utilization of drugs by prescribers rather than a measure

of increasing drug costs, per se. Utilization of drugs

in Canada, in terms of numbers of prescriptions filled,

increased by 1900 to a level of 240% of the 1940

prescription use rate.

### PART III - FURTHER EXPANSION OF PHARMACEUTICAL SERVICES

We advocate the institution of a voluntary

health care program, to include drug benefits in its

first stage and embracing the following principles:

1. Payment through an independent board largely representative of the professions providing the service.

2. Participants' freedom of choice of pharmacist.

3. Prescribers' freedom of choice of drug(s) but



1 a limitation on the quantity per prescription  
2 and quantity and frequency of repeat prescrip-  
3 tions.

4 4. An element of patient participation in the cost  
5 of each prescription supplied.

6  
7 PART IV - FUTURE COSTS

8 Many variable factors make it virtually  
9 impossible to arrive at cost figures which would result  
10 from the institution of a health care program. It would  
11 appear, however, that the utilization of drugs will  
12 continue to climb and as a consequence drug costs will  
13 probably increase as a proportion of the total health  
14 care dollar.

15  
16 PART V - METHODS OF FINANCING

17 We believe that the population of the  
18 province falls into three categories on the basis of  
19 financial ability to meet health care costs:

20 1. Welfare cases.

21 2. Low income groups who do not qualify for welfare  
22 benefits.

23 3. The remainder of the population who are able to  
24 meet the majority of their health care costs.

25 We advocate a graduated scale of government  
26 subsidization of a health care program based on the  
27 numbers of each participant in the above mentioned  
28 categories and suggest the possibility of such subsidiza-  
29 tion being undertaken on a federal-provincial cost  
30 sharing basis.



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1 PART VI - PHYSICAL FACILITIES AND PERSONNEL

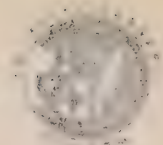
2 On the basis of 1940 - 60 records and  
3 projections to 1980, we believe the physical facilities  
4 in the way of retail pharmacies in the province to be  
5 adequate to ensure a high standard of service and avail-  
6 ability through 1980, even allowing for a possible  
7 increase in demand for such service should a health care  
8 program involve a large part of the population.

9 A study of student enrollment and  
10 pharmacist registration during 1940 - 60 and a projection  
11 of personnel requirements through 1980 indicates the  
12 probability that Pharmacy in British Columbia will be  
13 hard pressed to meet those requirements. We believe the  
14 fall in enrollment to be due in part at least to the  
15 relatively high cost of pharmaceutical education, a fact  
16 which we believe also applies to other health professions.

17  
18 PART VII - CONCLUSIONS AND RECOMMENDATIONS

19 1. There is a need for the expansion of  
20 health services in British Columbia, particularly to  
21 certain segments of the population, and we therefore  
22 recommend: THAT the Commission consider as its first  
23 recommendation the establishment of a voluntary,  
24 comprehensive health care program.

25 2. A compulsory health care program would  
26 be inimical to the democratic right of British Columbians  
27 to participate or not participate in such a plan as they,  
28 individually, see fit and we therefore recommend:  
29 THAT the Commission consider as a prime requisite of  
30 any health care program envisaged by its deliberations



1947

REPORT OF THE COMMISSION ON THE HEALTH CARE PROGRAM

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PART VII - CONCLUSIONS AND RECOMMENDATIONS

1. There is a need for the expansion of

health services in British Columbia, particularly to certain segments of the population, and we therefore recommend: THAT the Commission consider as its first recommendation the establishment of a voluntary,

comprehensive health care program.

2. A compulsory health care program would

be inimical to the democratic right of British Columbians to participate or not participate in such a plan as they individually, see fit and we therefore recommend:

THAT the Commission consider as a prime objective of

any health care program envisaged by its deliberations



1 that participation in such a program be voluntary  
2 (paragraphs 17, 54).

3 3. The provisions of medical care alone does  
4 not constitute comprehensive health care; the medical  
5 practitioner must be provided with the therapeutic tool  
6 of drugs if and when he requires them in the treatment  
7 of his patients. We therefore recommend:

8 THAT the Commission consider as one of the minimum initial  
9 requirements of a comprehensive health care program the  
10 provision of drug and pharmaceutical services  
11 (paragraphs 18, 55, 58, 59).

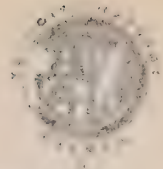
12 4. The participants in a voluntary, compre-  
13 hensive health care program must be able to exercise  
14 freedom of choice of pharmacist from whom they wish to  
15 obtain drug benefits under such a program and we therefore  
16 recommend:

17 THAT the Commission strongly affirm in its findings that  
18 drug benefits in a health care program be available to  
19 participants through all legally established outlets of  
20 drug distribution with no restriction on the participants'  
21 choice of pharmacist (paragraph 19).

22 5. The prescriber of drugs must be free to  
23 choose the drug(s) he deems to be in the best interest  
24 of his patient, without any limitation on the range of  
25 such choice and we therefore recommend:

26 THAT the Commission limit any recommendation with respect  
27 to restriction on drug benefits in a health care program  
28 to a control of quantity of drug(s) per prescription and  
29 the quantity and frequency of repeat prescriptions  
30 (paragraphs 20, 60, 61, 62, 63).





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(paragraphs 20, 21, 22, 23).



1 6. Experience in various health care plans  
2 extant today indicates the need of an element of economic  
3 control as a deterrent to over-utilization of drug  
4 benefits and we therefore recommend:

5 THAT the Commission consider as mandatory an element of  
6 patient participation in the cost of each prescription  
7 supplied as a benefit under a comprehensive health care  
8 program (paragraphs 21, 64, 65).

9 7. The members of the professions supplying  
10 services in a health care program are best qualified to  
11 operate such a program, including the determination of  
12 scales of remuneration, and must be as free as possible  
13 from outside influence in doing so and we therefore  
14 recommend:

15 THAT the Commission recommend that any health care program  
16 resulting from its studies should be initiated, developed  
17 and administered by an independent board, commission or  
18 corporation largely representative of the professions  
19 supplying services under the program (paragraphs 22, 76,  
20 77).

21 8. There is a need for government assistance  
22 in the financing of a health care program and this need  
23 varies amongst different segments of the population and  
24 we therefore recommend:

25 THAT the Commission study the possibility of graduated  
26 subsidization of a health care program and a system of  
27 cost sharing between federal and provincial levels of  
28 government (paragraphs 75, 78).

29 9. The institution of a health care program  
30 program will create an increased need for personnel in



THE GOVERNMENT OF ONTARIO

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1 the professions providing services in such a plan and we  
2 therefore recommend:  
3 THAT the Commission consider as one of its recommendations  
4 federal government assistance to students undertaking  
5 training in the health professions either in the form of  
6 scholarships, bursaries, etc., or through direct subsidi-  
7 zation (paragraphs 114, 115).

8 Mr. Chairman and members of the Commission,  
9 this concludes the summary of our brief, but before  
10 enviting your questions, sir, there is one further  
11 matter I would like to discuss briefly, if I may.

12 THE CHAIRMAN: Feel free to develop the  
13 matter in any way that you think is best so far as your  
14 submission is concerned.

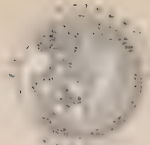
15 MR. DENHOLM: Thank you, sir.

16 That portion of our brief having to deal  
17 with the present cost of drugs and pharmaceutical  
18 services has been devoted exclusively to prescribed  
19 drugs. It has been drawn to our attention that the  
20 Commission has at some of its earlier hearings evidenced  
21 an interest in the cost of non-prescribed drugs. We  
22 have tried to gather some information on this subject  
23 in an effort to be of further assistance to you.

24 THE CHAIRMAN: What we have been calling  
25 "over-the-counter" drugs?

26 MR. DENHOLM: That is it, sir.

27 I must state with some regret that very  
28 little information is available. In the United States,  
29 a study by the Health Insurance Association of America  
30 cites a 1959 report of the Health Information Foundation



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1 and a 1958 Columbia Univeristy pilot study of this  
2 subject. Both these studies indicate that non-prescribed  
3 drugs constitute thirty-three per cent of total drug  
4 purchases. That is approximately fifty per cent of the  
5 amount spent on prescribed drugs. No details are given  
6 as to how this figure was arrived at, nor is there any  
7 indication of the scope of non-prescribed drugs used as  
8 a basis for the calculation.

9                   The Canadian Sickness Survey of 1951  
10 showed drug and appliances as amounting for 20.1 per  
11 cent of total health care costs, and the survey has been  
12 broken down as follows: Medicine prescribed, 12.3 per  
13 cent; medicine not prescribed, 7.2 per cent; appliances  
14 and equipment, .6 per cent. Omitting the appliances,  
15 these figures indicate expenditures for non-prescribed  
16 drugs were 58.5 per cent of the amount expended for  
17 prescribed drugs, or 36.9 per cent of the total,  
18 somewhat higher than the estimated American figures  
19 previously referred to.

20                   It is possible that these ratios may  
21 not be valid today because of the great increase in the  
22 utilization of prescribed drugs which may well have the  
23 effect of decreasing the degree of self-medication  
24 undertaken in the field of non-prescribed drugs.

25                   Further, it is not known, again, on  
26 what basis the Canadian Sickness Survey determined what  
27 constitutes non-prescribed drugs.

28                   It is interesting to note that the  
29 Dominion Bureau of Statistics in its periodic issues  
30 of cost of living indices noted as of 1960 lists the





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It is interesting to note that the Dominion Bureau of Statistics in its periodic issues of cost of living indices noted as of 1960 that the



1 cost index formerly referred to as drugs as pharmaceuti-  
2 cals, and this has been broken down into four categories:  
3 headache tablets, vitamins, bandages and prescriptions.  
4 The 1960 index based on the 1949 base of one hundred  
5 shows the over-all index for pharmaceuticals to be  
6 127.3; headache tablets, 118.8; vitamins, 107.1;  
7 bandages, 169.4; and prescriptions, 112.9.

8 Now, this only indicates the costs of  
9 these items relative to 1949 and not relative to each  
10 other, and it is of no help in determining the proportion  
11 of non-prescribed to prescribed drugs.

12 It is interesting to note the line of  
13 demarcation used by the Dominion Bureau of Statistics  
14 the line leading to many questions, such as in which  
15 category are prescribed headache tablets and prescribed  
16 vitamins. If bandages are pharmaceuticals, what about  
17 adhesive tape, absorbent cotton and gauze, etcetera,  
18 and in what index are included many common non-prescribed  
19 stomach preparations, non-prescribed vitamin tonics,  
20 liniments and so on.

21 Mr. Chairman, there may be a method  
22 of determining the cost of non-prescribed medication,  
23 but the information does not appear to be available at  
24 the present time, I regret it was beyond our facilities  
25 to obtain anything further.

26 Some caution should perhaps be under-  
27 taken in considering any move which might have the  
28 affect of encouraging self-medication. Certainly the  
29 population is daily subjected to the blandishment of  
30 commercial orientated promotions as panaceas for



cost index formerly referred to as drugs as pharmaceuticals, and this has been broken down into four categories: headache tablets, vitamins, bandages and prescriptions. The 1960 index based on the 1949 base of one hundred shows the overall index for pharmaceuticals to be low, this only indicates the costs of these items relative to 1949 and not relative to each other, and it is of no help in determining the proportion of non-prescribed to prescribed drugs. It is interesting to note the line of demarcation used by the Dominion Bureau of Statistics the line leading to many questions, such as in which category are prescribed headache tablets and prescribed vitamins. If bandages are pharmaceuticals, what about adhesive tape, absorbent cotton and gauze, etcetera, and in what index are included many common non-prescribed stomach preparations, non-prescribed vitamin tonics, liniments and so on. Mr. Chairman, there may be a method of determining the cost of non-prescribed medication, but the information does not appear to be available at the present time. I regret it was beyond our facilities to obtain anything further. Some caution should perhaps be undertaken in considering any move which might have the effect of encouraging self-medication. Certainly the population is daily subjected to the blandishment of commercial orientated promotions as panaceas for





1 virtually every ill known to man. We would draw your  
2 attention to the statement made yesterday by the  
3 Canadian Medical Association, British Columbia Division,  
4 a statement with which we concur.

5 Any suggestion that non-prescribed  
6 medication should be included as a benefit in a health  
7 care programme, should, we believe, be based on a  
8 consideration of specific medications in this category.

9 The following qualifications should be  
10 made:

11 1. That the medication is not one  
12 ordinarily prescribed and over the use of which medical  
13 supervision is not necessary;

14 2. That there is a valid and  
15 appreciable need for the medication, and

16 3. That the cost of the medication  
17 is sufficiently appreciable to constitute an economic  
18 hardship on the user.

19 It is difficult to name a single drug  
20 or proprietary medicine which meets all these qualifica-  
21 tions.

22 We believe that any further investiga-  
23 tion of the subject which the Commission may undertake  
24 will reveal very few, if any, non-prescribed drugs  
25 which are costly for which there is a valid and  
26 appreciable need and which may be properly used without  
27 medical supervision.

28 Mr. Chairman, we now invite your  
29 questions.

30 THE CHAIRMAN: Mr. Denholm, perhaps



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1 I might draw to your attention in regard to your  
2 statement that you are disturbed to note that there has  
3 been no appointment of a pharmaceutical consultant.  
4 We, at this stage, cannot add to the personnel of the  
5 Commission which, of course, was constituted in June.  
6 However, so far as having consultants  
7 and assistance from those who are pharmacists, we have  
8 Professor Finlay Morrison of the University of British  
9 Columbia, who is our consultant and is doing a research  
10 project for us in the recruitment and utilization of  
11 pharmacists in Canada. We have Mr. P. M. Ross, who is  
12 the associate secretary of the Canadian Pharmaceutical  
13 Association, who is doing the research and study project  
14 on the manpower of pharmacists in Canada. We have had  
15 with us in each province Professor Summers of the Univer-  
16 sity of Saskatchewan at Saskatoon who has been available  
17 to us for consultation and advice and regarding whom  
18 we are pleased to acknowledge his assistance to date.  
19 So that in this sense I do not think you need continue  
20 to be so disturbed.

21 MR. DENHOLM: I appreciate your  
22 statement, thank you.

23 COMMISSIONER BALTZAN: Page 3.

24 MR. DENHOLM: Of the brief or the  
25 summary?

26 COMMISSIONER BALTZAN: The summary,  
27 the second paragraph:

28 "Utilization of drugs in Canada, in  
29 terms of numbers of prescriptions filled,  
30 increased by 1960 to a level of 240%





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1 of the 1940 prescription use rate."

2 That certainly is shocking but there  
3 has been a change in respect to population. Can you at  
4 this time or later perhaps tell us what the percentage  
5 of prescription per population was in 1940, what it was  
6 in 1960, and then maybe we would be a little bit less  
7 shocked if we subtract one from the other.

8 MR. DENHOLM: This point in the  
9 summary refers to a table in the brief which gives the  
10 information you have requested.

11 COMMISSIONER BALTZAN: Would you read  
12 that?

13 MR. DENHOLM: This is paragraph 51  
14 on page 18 of the brief proper. I would point out that  
15 the 240 per cent that we referred to in the summary is  
16 a per capita increase. As you will see from this table  
17 it is related directly to population; in 1940 one  
18 prescription per person in Canada; in 1950 2.06  
19 prescriptions per person in Canada; in 1960 2.40  
20 prescriptions per person in Canada.

21 COMMISSIONER BALTZAN: That is very  
22 good of you but I think I will have to leave it to the  
23 economists because I do not know too much about figures  
24 and the breakdown. Apparently it suggests that there  
25 is a difference or is there a difference if the number  
26 of prescriptions increase so much in a ten year period  
27 as against the percentage of population, say, per  
28 thousand?

29 MR. DENHOLM: Well, referring again  
30 to the table, the population increased from, let us take



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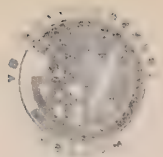
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2 1940 to 1960, an increase of fifty per cent approximately.  
3 The prescriptions per person went up from one per person  
4 to 2.4 per person, two and a half times. Does that  
5 answer your question?

6 COMMISSIONER BALTZAN: I think it  
7 does but I will have to figure it out a little later.  
8 That concerns me because the question is always asked  
9 whether we are becoming a nation of pill swallowers.  
10 With your suggestion there is an increase, let us  
11 assume and I take it as such, but I just want to ask  
12 you these questions in addition to that. Can part of  
13 this increase which you were good enough to point out  
14 to us be accounted for my more drugs being placed on  
15 a prescription list than formerly, especially those  
16 drugs that cause habituation, you now require prescrip-  
17 tions where ten or fifteen years ago you did not, in  
18 part?

19 MR. DENHOLM: You mean the restricted  
20 list?

21 COMMISSIONER BALTZAN: Yes, so many  
22 things you handed over the counter before and now you  
23 must have a prescription.

24 MR. DENHOLM: I would think not.  
25 There has been, of course, a tremendous increase in the  
26 number of drugs available generally whether restricted  
27 or not. I do not have statistics to back this up, but  
28 I would think that the number of drugs restricted to  
29 prescription sale only in 1940 relative to the outside  
30 range of drugs would fall into pretty much the same



round figures, eleven million to seventeen million from 1940 to 1960, an increase of fifty per cent approximately. The prescriptions per person went up from one per person to 2.4 per person, two and a half times. Does that

answer your question?

does but I will have to figure it out a little later. That concerns me because the question is always asked whether we are becoming a nation of pill swallowers. With your suggestion there is an increase, let us assume and I take it as such, but I just want to ask you these questions in addition to that. Can part of this increase which you were good enough to point out to us be accounted for by more drugs being placed on a prescription list than formerly, especially those drugs that cause habituation, you now require prescriptions where ten or fifteen years ago you did not, in

MR. DENHOLM: You mean the restricted

list?

COMMISSIONER BALDWIN: Yes, so many

things you handed over the counter before and now you must have a prescription.

MR. DENHOLM: I would think not.

There has been, of course, a tremendous increase in the number of drugs available generally whether restricted or not. I do not have statistics to back this up, but I would think that the number of drugs restricted to prescription sale only in 1940 relative to the outside range of drugs would fall into pretty much the same



1 category as we have today. The number of restricted  
2 drugs relative to the much larger range.

3 COMMISSIONER BALTZAN: I am thinking  
4 of such things as barbituates.

5 MR. DENHOLM: Yes.

6 COMMISSIONER BALTZAN: At one time  
7 you hardly needed a prescription and now you do.

8 MR. DENHOLM: We are speaking of 1940  
9 and you certainly needed a prescription for barbituates  
10 in 1940.

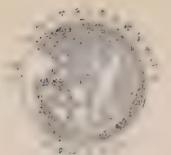
11 COMMISSIONER BALTZAN: In 1940 a  
12 prescription containing a quarter grain of codeine you  
13 could get but for one-half a grain you needed a doctor's  
14 prescription.

15 MR. DENHOLM: Actually today the  
16 division is one-eighth of a grain.

17 COMMISSIONER BALTZAN: Is this great  
18 upsurge in the use of drugs because so many of these  
19 drugs have been found so beneficial in the treatment of  
20 mental disorders, something we did not have up until  
21 about five years ago?

22 MR. DENHOLM: Yes, on drug therapy  
23 in the field of mental disease it has certainly expanded  
24 tremendously in the last few years. This is only one  
25 of the extensions. During this period of 1940 to 1960  
26 we have seen the introduction of the antibiotics which  
27 have become more and more widely used as an alternative  
28 method of therapy to previously used methods; the  
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1 people to hospital and so on.

2 COMMISSIONER BALTZAN: And you would  
3 add the hypoglycemic agents which cut down the use of  
4 insulin and the anti-tuberculosis drugs which have  
5 emptied our sanatoria by half?

6 MR. DENHOLM: Any number of such  
7 developments in the last twenty years.

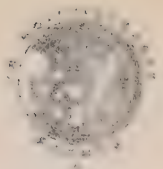
8 COMMISSIONER BALTZAN: So the picture  
9 should look a little bit less shocking?

10 MR. DENHOLM: I do not think it is  
11 shocking really unless it was related to other forms of  
12 treatment. It is our belief that it would appear on the  
13 basis of figures, although figures are not always a  
14 reliable index, that drug therapy is in many cases  
15 being used by the physician as an alternative to other  
16 methods of treatment that were formerly used. If that  
17 is so it is not really shocking to see so much drug is  
18 being used unless it is related to reductions in other  
19 forms of treatment.

20 COMMISSIONER BALTZAN: Mr. Denholm,  
21 I am not discussing principles, I just want to get these  
22 few things cleared up.

23 COMMISSIONER GIRARD: I have no  
24 questions but I want to say that I read the appendix A  
25 on the hospital pharmacy services with a great deal of  
26 interest, especially the part that pertains to the Drug  
27 Administration and Nursing Act; there is some informa-  
28 tion there that I did not get in any other brief. I  
29 want to say I am very interested in reading it.

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1 pharmacist per one hundred beds, and I think in other  
2 briefs we have been told we should have one pharmacist  
3 for seventy-five, so there is a little variance in the  
4 amount.

5 MR. DENHOLM: I can assure you that  
6 if were possible we would like to see one pharmacist for  
7 every fifty bed hospital, but since we have no guide-  
8 line at the moment, we had to start somewhere and that  
9 is where we chose to start.

10 COMMISSIONER VAN WART: Mr. Chairman,  
11 may I ask, does the practice of issuing code prescriptions  
12 exist in British Columbia?

13 MR. DENHOLM: Issuing ----

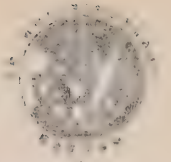
14 COMMISSIONER VAN WART: Issuing coded  
15 prescriptions?

16 MR. DENHOLM: No, sir.

17 THE CHAIRMAN: In the matter of your  
18 personnel, are you reasonably well supplied with  
19 pharmacists in British Columbia?

20 MR. DENHOLM: At the moment it is our  
21 belief that there is no acute shortage of pharmacists in  
22 the province. I should perhaps add to that that you will  
23 note we have pointed out at one stage of the brief that  
24 some thirty-five per cent of our new licentiates come  
25 to us from outside the province. I do not think it would  
26 be proper to answer your question flatly no, that we do  
27 not have a shortage because if for any reason this  
28 influx of outside pharmacists were to abate or cease, we  
29 would have serious personnel problems.

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1 rest of Canada?

2 MR. DENHOLM: The rest of Canada and  
3 from outside Canada although the bulk come from the rest  
4 of Canada.

5 THE CHAIRMAN: How many do you graduate  
6 a year into the profession in British Columbia?

7 MR. DENHOLM: This is contained in  
8 table D on page 36 of the main brief. The number of  
9 students graduating from the Faculty of Pharmacy in 1961  
10 was forty; in 1960, thirty-two; in 1959, thirty-three;  
11 in 1958, forty-one; in 1957, forty-one; in 1956,  
12 forty; it is in that area.

13 THE CHAIRMAN: What extra assistance  
14 by way of bursaries or scholarships is available to  
15 schools?

16 MR. DENHOLM: I would like to ask the  
17 Dean of the Faculty of Pharmacy, Dr. Matthews, to speak  
18 to that.

19 DR. MATTHEWS: I am very pleased to  
20 try to provide you with some information but if I might  
21 go back to the last question you asked and Mr. Denholm  
22 stated there was not an acute shortage of pharmacists  
23 in British Columbia at the present time. With this I  
24 will, of course, agree, but I would point out that we  
25 are one of eight schools of pharmacy in Canada training  
26 pharmacists and we train pharmacists for other fields  
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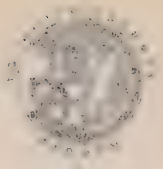


1 is being done that might more properly be done by  
2 pharmacists and probably more efficiently done by  
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4 But, to answer your direct question  
5 about help that is now available; there are a few  
6 bursaries available to students provided in the main  
7 through pharmaceutical sources. We have in Canada a  
8 foundation, a Canadian foundation for the advancement  
9 of pharmacy that provides a small amount of assistance  
10 for students in various capacities, bursaries, scholar-  
11 ships and loans. There are scholarships available at  
12 various levels in the university in general of which we  
13 have access to a few that are non-pharmacy scholarships;  
14 in the main, we rely on the scholarships that are  
15 provided by our friends and colleagues.

16 Then, of course, in this province we  
17 also have scholarship assistance provided by the provin-  
18 cial government to all students who obtain first class  
19 standing in their studies. These students receive one-  
20 half of their tuition and a limited number of those who  
21 make the second class standing in their studies, taking  
22 the higher proportion of that group, receive one-third  
23 of their tuition fees.

24 THE CHAIRMAN: Now, on the question  
25 of utilization, the discussion between Dr. Baltzan and  
26 Mr. Denholm dealt with the number of prescriptions per  
27 capita; in the matter of these prescriptions are you able  
28 to give a figure percentage-wise of the number that are  
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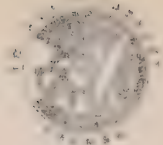


1 MR. DENHOLM: Yes, sir. Appendix B,  
2 page 4 in British Columbia 1960 compounded prescriptions  
3 accounted for three per cent of the total number of  
4 prescriptions and 2.5 per cent of the total dollar volume.

5 THE CHAIRMAN: Would you be able to  
6 translate that into the percentage of time, the time  
7 spent by a pharmacist doing the compounding as distinct  
8 from the putting together of the previously prepared  
9 medication?

10 MR. BROWN: I am afraid any statement  
11 would just be hazarding a guess at this time.

12 DR. MATTHEWS: I would agree that it  
13 is not possible to give a figure as regard to proportion  
14 of time. However, I think I know the thought that is in  
15 your mind and I would like to make an observation.  
16 First of all, may I point out that it would vary consider-  
17 ably because if the pharmacist happened to be in an  
18 area where a dermatologist was practising he might find  
19 that his proportion of compounded prescriptions would be  
20 very much higher than the average. This might also  
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25 Dr. Baltzan asked earlier about the effect of the restric-  
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5 compounded and non-compounded prescriptions.

6 COMMISSIONER BALTZAN: Would it also  
7 make a difference between compounding and the dispensing  
8 of prescriptions where the physician is of an older age  
9 than much younger physicians?

10 DR. MATTHEWS: I did not get that.

11 COMMISSIONER BALTZAN: Could the  
12 question of compounding be related to the age of the  
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14 DR. MATTHEWS: It could conceivably be  
15 to a very minor extent.

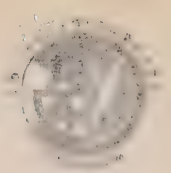
16 THE CHAIRMAN: I do not know whether  
17 Dr. Baltzan means it would take longer to read the  
18 doctor's writing.

19 MR. DENHOLM: That is always a problem.

20 THE CHAIRMAN: On this matter of  
21 utilization are you in a position to give, percentage-  
22 wise as an approximation, the time that the average  
23 pharmacist puts in as a pharmacist, that is, the average,  
24 what we call the corner drug store druggist puts in as  
25 a pharmacist as distinguished from the time he puts in  
26 in selling all the other products that are sold in the  
27 drug store?

28 MR. DENHOLM: I think the only state-  
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3 "Prescriptions accounted for an average  
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8 per cent of the retail pharmacists'  
9 activities are concerned with matters not  
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11 This is not properly true, however, since  
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18 tion accessories and surgical supplies."

DD 19 THE CHAIRMAN: If I put the question  
20 at that point, does a person have to be a pharmacist to  
21 do those latter things, that is, in the distribution of  
22 drugs and poisons which are not generally included in  
23 the prescription category and also in the sale of  
24 prescription accessories and surgical supplies?

25 MR. DENHOLM: Certainly in the first  
26 part, the first part of your question the answer is  
27 legally, yes, the pharmacist must. There is a wide range  
28 of drugs and poisonous materials that are restricted  
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1 THE CHAIRMAN: That has nothing to  
2 do with prescriptions?

3 MR. DENHOLM: In this latter field  
4 there is no legal requirement that a pharmacist sell  
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6 person with pharmaceutical training and knowledge in this  
7 field should provide this service to the public along  
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9 THE CHAIRMAN: Yes. Now, this  
10 question is aimed at seeing if there is any method of  
11 utilizing the graduates of our schools of pharmacy as  
12 pharmacists rather than as part-time pharmacists and  
13 part-time vendors of the other things that are sold in  
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19 the same result by graduating twenty-five who worked  
20 full time as druggists?

21 MR. DENHOLM: We deal with this  
22 indirectly at a couple of points in the brief, sir.  
23 Perhaps I may refer to it.

24 THE CHAIRMAN: Indeed, because your  
25 views on this subject are important.

26 MR. DENHOLM: While I am locating this,  
27 Dr. Matthews has a comment.

28 THE CHAIRMAN: I would be pleased to  
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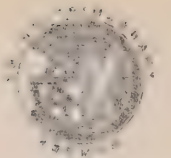
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2 I would like to enlarge a little bit on my terms of  
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4 question, or the earlier answer of Mr. Denholm about the  
5 sale of prescription accessories and specialties such  
6 as hypodermic needles, surgical supplies, and various  
7 things of that sort. There are still other areas where  
8 we feel the pharmacist is definitely utilizing his  
9 training outside of the dispensary proper.

10 I would mention, for example, vaccine  
11 storage that the pharmacist carries out for public health  
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19 if he is in a rural area, between the patient, the  
20 doctor, and the poison control centre which may now be  
21 set up and not in the immediate locality.

22 He provides, as I say, he many in many  
23 cases be the first contact that the particular person  
24 has in this regard, even before it is possible to locate  
25 the doctor. There are various things of this sort which  
26 our students, all having been required to take first aid  
27 as part of their curriculum, are expected to give  
28 service of this nature.

29 I would just like to say your question  
30 perhaps is more pertinent in urban areas than it is in





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I would like to enlarge a little bit on my terms of reference in this regard. In respect to your earlier question, or the earlier answer of Mr. Danholm about the sale of prescription accessories and specialties such as hypodermic needles, surgical supplies, and various things of that sort. There are still other areas where we feel the pharmacist is definitely utilizing his training outside of the dispensary proper.

I would mention, for example, vaccine storage that the pharmacist carries out for public health officials, particularly in rural areas. His storage facilities are most suitable for this purpose and there may not be a hospital in the area. This, of course, is time which he furnishes and gives more or less gratis. Various emergency service that he provides on a stand-by basis such as in connection with accidental poisoning and so on, where he may be the intermediary, particularly if he is in a rural area, between the patient, the doctor, and the poison control centre which may now be set up and not in the immediate locality.

He provides, as I say, he many in many cases be the first contact that the particular person has in this regard, even before it is possible to locate the doctor. There are various things of this sort which our students, all having been required to take first aid as part of their curriculum, are expected to give service of this nature.

I would just like to say your question perhaps is more pertinent in urban areas than it is in



1 rural areas, because the economics of the whole  
2 situation have more or less directed the trend that the  
3 community pharmacy has taken over a long period of years  
4 in Canada. We start with the population which by and  
5 large spirals, and the type of practice that was developed  
6 in these years has been suitable to that type.

7 As we get more populous centres and in  
8 the rural areas the trend is changing somewhat and can  
9 change more. It is my belief that the economics of the  
10 situation will mean a change and that the pharmacist,  
11 because he is, himself, a trained man, and therefore  
12 in the category of high priced help, will be forced to  
13 more or less direct himself back into the professional  
14 areas than he has been in the past.

15 In the urban areas the situation is  
16 still quite different, in my opinion, from the situation  
17 in the rural areas. I don't know whether that will assist  
18 you.

19 THE CHAIRMAN: Thank you very much.  
20 Would you care to amplify any further your views with  
21 respect to urban areas?

22 DR. MATTHEWS: No, I will let Mr.  
23 Denholm give you his answer first. I would be happier.

24 MR. DENHOLM: There are a couple of  
25 other matters. We are dealing in paragraph 25 to some  
26 extent with this subject, pointing out that we are aware  
27 of the fact there is some criticism of the time ----

28 THE CHAIRMAN: It may not be criticising.

29 MR. DENHOLM: A comment, let us say,  
30 sir.



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THE CHAIRMAN: It may not be criticism. A comment, let us say,





1 THE CHAIRMAN: Where there is a  
2 process of evolution going on.

3 MR. DENHOLM: I think I can show you,  
4 that there is, sir, of the time spent by the pharmacist  
5 in the merchandizing of what wouldn't be described  
6 ordinarily as articles of commerce having to do with  
7 drugs and pharmacy.

8 However, we point out it can be shown  
9 and has been shown statistically if we are to maintain  
10 the availability of pharmacies that we presently have,  
11 the availability of services, that the pharmacists must  
12 subsidize the dispensary operation through these other  
13 avenues. Whether this is done to too great a degree is  
14 an open question which I wouldn't like to answer.

15 THE CHAIRMAN: It brings you to same  
16 proposition whether you should have a drug store on every  
17 corner or a filling station on every corner.

18 MR. DENHOLM: Quite so, sir.

19 As to trend, tables B and C on pages  
20 28 and 29 indicate from 1940 to 1960 the ratio of  
21 pharmacies, drug stores per capita changed from one to  
22 2,750, one drug store for every 2,750 people in 1940 to,  
23 in 1960, one to every 3,260, so the number of pharmacies  
24 per capita is decreasing.

25 Also it is noted that the number of  
26 pharmacists per pharmacy are increasing to the point of  
27 raising from 1.8 pharmacists per pharmacy to 2.3 over  
28 the same twenty year period.

29 We note, sir, in paragraph 90 of the  
30 brief and it is pertinent to your question and may I





1 read it:

2 " Further, the Association believes  
3 that a decrease in the number of  
4 pharmacies relative to the population  
5 such as that envisaged -- "

6 I should go back and say we have some projections to  
7 1970 and 1980 on this basis --

8 "herein might well have the effect of  
9 decreasing the degree of economic  
10 subsidization through sale of non-  
11 pharmacy items presently necessary to  
12 maintain a comprehensive prescription  
13 service in the average pharmacy. We  
14 are already noting an increase in the  
15 establishment of pharmacies devoting  
16 themselves entirely to the provision of  
17 prescription service and the sale of  
18 drugs. We believe that this trend to  
19 specialization coupled with an increased  
20 average number of persons to be served  
21 by each pharmacy will make it possible  
22 for the average pharmacy to rely to a  
23 growing extent on prescription business  
24 and drug sales without requiring the  
25 economic crutch of diversified sundry  
26 sales to support its professional activi-  
27 ties. The Association would view such  
28 a development as being in the long-range  
29 interests of the profession of Pharmacy.  
30 For the very reason as you state, the





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1 increase in the utilization of the professional training.

2 Before we leave this question I would  
3 like Mr. Brooks, the hospital pharmacist to comment on  
4 the devotion of a hospital pharmacist to matters directly  
5 concerning drug distribution and other matters concerning  
6 drugs.

7 MR. BROOKS: If you will agree with  
8 me, I am a full-time pharmacist under your meaning I feel I  
9 spend no more time actually devoted to the actions or  
10 the mechanics of dispensing than the average corner  
11 drug store. The rest of my time is devoted to the volume  
12 of paper work existing in hospitals and the other related  
13 functions of a department head within a hospital,  
14 purchasing, teaching duties in some cases that some of  
15 the hospitals perform, and all the other related and  
16 sundry items thereto.

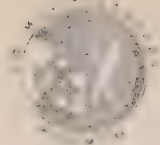
17 THE CHAIRMAN: Thank you, Mr. Brooks.

18 COMMISSIONER BALTZAN: You have to  
19 handle the intravenous solutions in the hospital, haven't  
20 you?

21 MR. BROOKS: It varies from hospital  
22 to hospital and from pharmacy to pharmacy department.  
23 Largely they are under the direction, whether direct or  
24 indirect of the pharmacy department, medical gases as well,  
25 and in many cases, medical surgical supplies, laboratory  
26 chemicals, x-ray solutions and so on.

27 DR. MATTHEWS: You asked if I would  
28 make a further comment.

29 There appears to be an increasing trend  
30 in the direction of more professional work being done by



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1 the pharmacist.

2 THE CHAIRMAN: Your association  
3 accepts that as a desirable trend?

4 DR. MATTHEWS: A desirable trend,  
5 and we also say in the expressed wishes of our students,  
6 expressing the desire to be more active in that field.

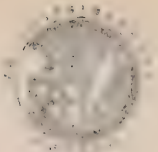
7 I would also point out to you there is  
8 a very definite percentage of the students who have the  
9 other desire; in other words, they are interested in the  
10 merchandizing aspects of pharmacy. I think they have  
11 an equal place in the profession and in the picture of  
12 pharmacy in general because this is the type of practice  
13 they are attracted to just as in the medical profession  
14 there are people attracted to general practice and others  
15 attracted to specialties and so on. I think that is  
16 parallel in the other fields.

17 The final comment is we believe there is  
18 room in pharmacy today, not only in hospital pharmacies  
19 but in the community pharmacies for the pharmacist to  
20 be a greater service to his physician in the matter of  
21 consultation on drugs. We are training our students in  
22 this area and they want to be of more service. They want  
23 to be active in this, for the physician to take advantage  
24 of this service outside the hospital as he gets it in  
25 the hospital.

26 THE CHAIRMAN: Thank you very much, Dr.  
27 Matthews.

28 MR. DENHOLM: Have we answered your  
29 question?

30 THE CHAIRMAN: It isn't a matter of



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to be active in that, for the physician to take advantage

of this service outside the hospital as we give it in

the hospital.

THE CHAIRMAN: Thank you very much, Dr.

Matthews.

MR. DEWOLFE: Have we answered your

THE CHAIRMAN: It isn't a matter of



1 convincing or unconvincing. What we are interested in  
2 is getting your views, and particularly at this stage,  
3 the views of an organization in a large city like  
4 Vancouver where you have access to a school of pharmacy  
5 and a knowledgeable man like Dr. Matthews.

6 COMMISSIONER FIRESTONE: Mr. Denholm,  
7 on page 2, the last line of your recommendations.

8 MR. DENHOLM: The summary?

9 COMMISSIONER FIRESTONE: The summary  
10 of recommendations, you say that hospital and government  
11 institutions purchase many drugs at very much lower  
12 prices than are paid for the same drugs by retail  
13 pharmacists. Can you give us an example of a drug sold  
14 frequently in retail pharmacies that would illustrate  
15 that point to us?

16 MR. DENHOLM: Yes, sir, chlorpormazine,  
17 sir.

18 COMMISSIONER FIRESTONE: What is this  
19 drug used for?

20 MR. DENHOLM: This is a drug used  
21 largely in the field of mental health. I might add, sir,  
22 that is indicated in our brief, paragraph 45 on page 10  
23 and referring to number 8 of our bibliography, that ample  
24 other examples of this nature are contained in the  
25 Green Book, with which I believe you are familiar, sir.

26 COMMISSIONER FIRESTONE: I am quite  
27 happy with one example. We only want one to use as an  
28 example to illustrate the point.

29 What is the price of chlorpormazine as  
30 sold at the retail level by pharmacists in Vancouver?





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example to illustrate the point.

What is the price of chlorpromazine as

sold at the retail level by pharmacists in Vancouver?



1 MR. DENHOLM: I couldn't give you  
2 that information off the cuff.

3 COMMISSIONER FIRESTONE: Could somebody  
4 among your colleagues?

5 MR. BROWN: This is kind of abstract  
6 because chlorpormazine is a generic name. Do you mean  
7 by generic name or under a trade name purchases?

8 COMMISSIONER FIRESTONE: Most of these  
9 drugs, is chlorpormazine sold more under generic name  
10 or trade name?

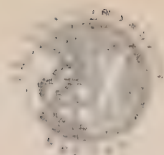
11 MR. BROOKS: I am afraid I couldn't  
12 truthfully answer that, not knowing the extent it is  
13 used in hospitals and mental institutions.

14 COMMISSIONER FIRESTONE: Could I  
15 perhaps turn to you as a practising pharmacist and ask  
16 you to give us an example using a trade name type of drug  
17 commonly sold on a prescription basis by the retail  
18 pharmacists, and then we could get the price that it  
19 comes to you and we will ask your colleague whether he  
20 can give us a similar price for the hospital so we can  
21 get some illustration of the point that is being made.  
22 I will leave the choice of the example to you.

23 MR. BROOKS: I am afraid I don't have  
24 the information at my finger tips.

25 COMMISSIONER FIRESTONE: You can't  
26 recall one single drug that you sell over the counter on  
27 prescription, what the price would be?

28 MR. BROWN: That would also be applic-  
29 able to purchases in a large institution, government  
30 hospitals.



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1 MR. DENHOLM: Mr. Commissioner, if I  
2 may interrupt, I don't think it would serve the best  
3 interests of the Commission in gathering information if  
4 we were to rely on memory to provide you with the  
5 information you have requested. If you wish us to supply  
6 that information in a written submission later we will  
7 be happy to do so.

8 COMMISSIONER FIRESTONE: That is a  
9 fair suggestion, sir. It would be very helpful to us.  
10 What we would like to have is some concrete evidence to  
11 substantiate the claim made in your submission. If you  
12 could let us have some drug that is sold under trade  
13 name, and then under generic name, and the comparable  
14 cost or price level that applies to the hospital, if this  
15 information could be supplied to us subsequently it would  
16 be very helpful.

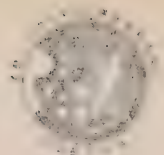
17 MR. DENHOLM: That will be done, sir.

18 COMMISSIONER FIRESTONE: Since we have  
19 no figures before us, can we perhaps deal with the  
20 principal reason behind this claim that you made that  
21 hospital and government institutions purchase many drugs  
22 at a very much lower price than that paid for the same  
23 drug by retail pharmacists. Can you offer any reasons  
24 why this is the case?

25 MR. DENHOLM: Why the manufacturers  
26 sell to hospitals at lower prices?

27 COMMISSIONER FIRESTONE: Yes. And you  
28 say here at very much lower prices.

29 MR. DENHOLM: I think, sir, this is  
30 an answer you would have to obtain from the manufacturers



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MR. DENHOLM: I think, sir, this is



1 who may or may not be appearing before you at a later  
2 hearing. I do not know.

3 COMMISSIONER FIRESTONE: Has your  
4 association made any inquiries on this subject?

5 MR. DENHOLM: Inquiries as to why they  
6 do it?

7 COMMISSIONER FIRESTONE: As to why you  
8 have to pay so much more for drugs. After all, you are  
9 exposed to criticism by people -- or comments if you do  
10 not like the word criticism -- that your costs are high  
11 and surely when you are a responsible pharmacist you  
12 wonder why or whether people are not justified. You  
13 might want to come back and ask the people who supply  
14 the drugs why do I have to pay many times more for the  
15 same drug than the institution across the street, and I  
16 get all the blame for it. It is a natural human reaction,  
17 and I was just wondering whether you and your associates  
18 have ever considered the question?

19 MR. DENHOLM: Yes, sir. On behalf of  
20 our members, through our national organization, and it  
21 was done through our national organization since, as  
22 you understand, the majority, if not in fact all of the  
23 manufacturing of drugs in Canada is done in Eastern  
24 Canada. We have raised this question with the Canadian  
25 Pharmaceutical Manufacturers.

26 COMMISSIONER FIRESTONE: Good.

27 MR. DENHOLM: I cannot give you an  
28 outline of their answer. It is presently being raised  
29 with them, for that matter.

30 By the time the Canadian Association





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1 submits to you, they may have had an answer.

2 COMMISSIONER FIRESTONE: As I under-  
3 stand it, then from you, sir, that your national  
4 association has raised that question?

5 MR. DENHOLM: Yes, sir.

6 COMMISSIONER FIRESTONE: Would it be  
7 possible for you to advise your national association that  
8 if they receive the reply in the meantime that this  
9 Commission would appreciate greatly if that information  
10 would be passed on to them on the occasion that they are  
11 making their submission to us.

12 MR. DENHOLM: I would be pleased to  
13 advise them, sir.

14 COMMISSIONER FIRESTONE: On the  
15 subject about people claiming that drug costs are high,  
16 I think you have made in your submission in paragraph 48  
17 some very appropriate remarks, paragraph 48, page 17  
18 of your main submission.

19 MR. DENHOLM: Yes, sir.

20 COMMISSIONER FIRESTONE: You have  
21 pointed out that if the words "mounting cost of drugs"  
22 refer to the increasing amount of money that is being  
23 spent that this is largely a reflection of the mounting  
24 utilization of drugs?

25 MR. DENHOLM: Yes, sir.

26 COMMISSIONER FIRESTONE: And I think  
27 this point is generally not understood, and you have made  
28 a useful contribution to draw this point to the attention  
29 of our Commission, and we are grateful to you. But, as  
30 I understand it, some people complain about drug costs



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1 being high when they buy a single prescription, and in  
2 that case it is a question of price rather than quantity.

3 Now, I am just wondering that since  
4 your association, as well as other groups across the  
5 country, have run into this general complaint, whether  
6 you feel that it might be useful to have an impartial  
7 study concerning drug costs?

8 MR. DENHOLM: Could you repeat the  
9 question, sir?

10 COMMISSIONER FIRESTONE: Would you feel  
11 that it would be useful to have an impartial study  
12 concerning drug costs?

13 MR. DENHOLM: If such a study were  
14 limited, as you have limited your question, to drug costs,  
15 I would suggest that the information derived therefrom  
16 would be incomplete and therefore of little use.

17 If, however, such a study were expanded  
18 in scope to embrace the whole field of producing,  
19 distributing and selling of drugs, this may provide some  
20 useful information.

21 However, sir, I should point out that  
22 I believe this work has already been done for you by the  
23 Restrictive Trade Practices Commission during a series  
24 of hearings last year, and I believe that their findings  
25 will be made available in the very near future, and I  
26 would suggest that any consideration of a study of  
27 this subject be held in abeyance until the Commission  
28 has a chance to view these findings and see if they  
29 provide you with the information you require.

30 Have I answered your question, sir?



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1 COMMISSIONER FIRESTONE: I can assist  
2 you a little. The Commission is familiar with the work  
3 that has been done.

4 MR. DENHOLM: I am sure you are, sir.

5 COMMISSIONER FIRESTONE: And I assure  
6 you that the Combines Inquiry have been very co-operative  
7 and helpful to us in making available the green book and  
8 the hearings and we will, of course, have the results  
9 of their inquiry as well as their report and recommenda-  
10 tions.

11 MR. DENHOLM: Dr. Matthews would like  
12 to speak on this.

13 DR. MATTHEWS: I would just like to  
14 add one further expansion, if I may, to Mr. Firestone's  
15 proposed study, Mr. Chairman.

16 COMMISSIONER FIRESTONE: May I say I  
17 have not proposed a study. I have simply asked ---

18 DR. MATTHEWS: The one you have just  
19 suggested, then, sir.

20 COMMISSIONER FIRESTONE: I have asked  
21 Mr. Denholm about the advisability of such a study.

22 DR. MATTHEWS: Yes, I understand that,  
23 sir. In this study, if and when conducted, very careful  
24 attention should be paid to costs in relation to the  
25 efficacy of the drug.

26 In other words, what are these drugs  
27 producing in the way of therapeutic results compared to  
28 their costs in relation to the cost of other drugs.

29 COMMISSIONER FIRESTONE: Well, that is  
30 a very fair comment, sir, because when the people spend





You a little. The Commission is familiar with the work that has been done.

MR. DENHOLM: I am sure you are, sir.

COMMISSIONER FIRESTONE: And I assure you that the Compiles Inquiry have been very co-operative and helpful to us in making available the Green book and the hearings and we will, of course, have the results of their inquiry as well as their report and recommendations.

MR. DENHOLM: Dr. Matthews would like to speak on this.

DR. MATTHEWS: I would just like to add one further expansion, if I may, to Mr. Firestone's proposed study, Mr. Chairman.

COMMISSIONER FIRESTONE: May I say I have not proposed a study. I have simply asked --- suggested, then, sir.

COMMISSIONER FIRESTONE: I have asked Mr. Denholm about the advisability of such a study.

DR. MATTHEWS: Yes, I understand that sir. In this study, if and when conducted, very careful attention should be paid to costs in relation to the efficacy of the drug.

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COMMISSIONER FIRESTONE: Well, that is a very fair comment, sir, because when the people spend



1 money on something they want to know what they are getting  
2 for it. I think that is reasonably, Mr. Denholm.

3 THE CHAIRMAN: Meaning that if you  
4 get good value you don't care how much you pay?

5 DR. MATTHEWS: I do not imply that,  
6 sir.

7 MR. DENHOLM: I would like to say in  
8 connection with this matter that you quoted from part of  
9 paragraph 48. I think, however, that in fairness the  
10 latter part of that paragraph throws more light on the  
11 suggestion you make that there is a public concern  
12 regarding high drug costs.

13 COMMISSIONER FIRESTONE: I would be  
14 very happy if you read the whole paragraph into the  
15 record.

16 MR. DENHOLM: Paragraph 48:

17 "Much has been said in recent months  
18 about the "mounting cost of drugs". The  
19 use of the word "cost" in this context  
20 is a misnomer since the increasing amount  
21 of money being spent on drugs is largely  
22 a reflection of the mounting utilization  
23 of drugs. In actual fact the Dominion  
24 Bureau of Statistics Cost of Living  
25 Index indicates that the rise in drug  
26 cost remains below the overall rise in  
27 the cost of living. Using 1949 as a  
28 base (100) the index shows drugs at  
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30 all index in 1950, and 127.3 compared to

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101.5 as compared to 102.9 for the over-

all index in 1950, and 127.3 compared to





1 128.0 in 1960."

2 Now, I might just go a step further in  
3 that, sir. As I indicated to you earlier when we were  
4 discussing non-prescribed drugs, the Dominion Bureau of  
5 Statistics now rather than referring to drugs refers to  
6 pharmaceuticals, and we discovered after writing the  
7 brief that this 127.3 figure is really their figure of  
8 pharmaceuticals, and to put this in proper context,  
9 their figure for prescriptions should be used here --  
10 the prescription figure, 112.9.

11 This, I think, makes the comparison to  
12 the over-all cost index of 128 more marked.

13 Now, sir, while we are on this subject,  
14 I also draw to your attention the last table on pages 7  
15 and 8 of appendix D showing the distribution of  
16 prescriptions in 1960 in British Columbia by cost. I  
17 would draw to your attention that sixty per cent of all  
18 prescriptions were below the average prescription price  
19 of \$3.16 and seventy-five per cent of all prescriptions  
20 were under \$4.00 to the consumer, and only 1.4 per cent  
21 of all prescriptions were \$10.00 or more.

22 I believe these facts, sir, are not, as  
23 you said yourself earlier, commonly known.

24 COMMISSIONER FIRESTONE: Well, you are  
25 making very valuable contributions, I may say, in bringing  
26 these facts to the attention of the Commission and  
27 thereby to the attention of the public. There is quite  
28 rightly, as you suggested, and if I understand you correctly,  
29 perhaps a misconception of what the situation is, but  
30 presumably the best way of dealing with misconception is



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I am sure that you are aware of this.

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1 to study the situation and bring the facts to light.  
2 This is the basis of the question I have posed to you;  
3 whether you are in favour of such a study and assuming  
4 the inquiry of the Combines Commission does not cover  
5 all the aspects which we have been discussing, would you  
6 feel it would be desirable to have such a broader study  
7 as you have outlined?

8 MR. DENHOLM: Along the broad terms  
9 that I have outlined?

10 COMMISSIONER FIRESTONE: Correct, sir.

11 MR. DENHOLM: Yes, sir.

12 COMMISSIONER FIRESTONE: Thank you very  
13 much.

14 Now, if I may turn to page 4 of your  
15 recommendations -- that is, the summary of recommendations  
16 -- you start way out on the bottom of page 3 under  
17 part V, methods of financing. As I understand you, sir,  
18 your association is in favour of a pre-paid drug plan?

19 MR. DENHOLM: A pre-paid health care  
20 plan which will include --

21 COMMISSIONER FIRESTONE: Which will  
22 include drugs?

23 MR. DENHOLM: Yes.

24 COMMISSIONER FIRESTONE: In other  
25 words, you are looking at the pre-payment of drugs as  
26 part and parcel of a larger programme?

27 MR. DENHOLM: Yes, sir.

28 COMMISSIONER FIRESTONE: And you  
29 consider this, if I understood you correctly, an absolute  
30 essential part of such a broader programme?





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1 MR. DENHOLM: Drugs?

2 COMMISSIONER FIRESTONE: Yes, drugs.

3 MR. DENHOLM: Yes, sir.

4 COMMISSIONER FIRESTONE: You also say

5 in paragraph 3 on page 5 that the Commission consider

6 as one of the minimum initial requirements of a

7 comprehensive health care programme the provision of

8 drugs and pharmaceutical services. The word I would

9 like to question you on is the word "minimum" initial.

10 Do you mean by this that any health group care plan or

11 a health care plan as it may be recommended by this

12 Commission to the government should include as part of

13 the first stage or phase of that programme a pre-paid

14 drug plan as part of a broader health care programme?

15 MR. DENHOLM: Yes, sir.

16 COMMISSIONER FIRESTONE: That answers

17 my question. Thank you very much.

18 THE CHAIRMAN: Thank you very much,

19 Mr. Denholm, Dr. Matthews and your associations. This

20 has been a most helpful discussion and submission.

21 MR. DENHOLM: Thank you, sir.

22 THE CHAIRMAN: We will now recess for

23 a few minutes and then continue with the next submission.

24

25 --- Short recess

26

27

28

29

30



MR. DENHOLM: Drugs?

COMMISSIONER FIRESTONE: Yes, drugs.

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a few minutes and then continue with the next submission.

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1 THE CHAIRMAN: If you will come to  
2 order we will continue. The next brief is that of the  
3 British Columbia Hospitals Association.

4 THE SECRETARY: That will be exhibit  
5 No. 162.

6  
7 --- EXHIBIT NO. 162: Submission of the  
8 British Columbia Hospitals  
9 Association.

10 SUBMISSION

11 of the

12 BRITISH COLUMBIA HOSPITALS ASSOCIATION

13 APPEARANCES:

14 MR. J. V. HUGHES

15 MR. H. R. SLADE

16 SISTER LORETTO

17 MR. K. CONIBEAR

18  
19 THE CHAIRMAN: Who is the spokesman?

20 MR. SLADE: Mr. Chairman, we apologize  
21 for not presenting a written brief before but we were  
22 invited to be present to present a verbal brief and  
23 answer any questions. I would like to state that the  
24 British Columbia Hospitals Association have taken  
25 part in and completely approve a brief by the Canadian  
26 Hospitals Association that will be presented to the  
27 Commission in the future. We are in full support of  
28 that brief in its fullest detail. The brief from the  
29 Canadian Hospitals Association covers every part of any-  
30 thing to do with health in the Dominion.



THE CHAIRMAN: If you will come to order we will continue. The next brief is that of the British Columbia Hospitals Association.

THE SECRETARY: That will be exhibit

EXHIBIT NO. 102: Submission of the British Columbia Hospitals Association

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MR. J. V. HUNTER

MR. H. R. SLADE

MR. K. COMBES

THE CHAIRMAN: Who is the spokesman?

MR. SLADE: Mr. Chairman, we apologize

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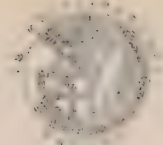
1 We are well aware that many briefs  
2 that have been presented across Canada will have a  
3 tremendous impact on the acute hospitals and there are  
4 many aspects of this. We know some of the requests by  
5 different associations might well increase the number of  
6 hospital beds required and other briefs will possibly  
7 cut down the need for hospital beds. The briefs, which  
8 I believe have been supplied to you, deal with very  
9 general subjects which we do not feel we should wish to  
10 elaborate on at this session unless you wish to ask any  
11 specific questions.

12 One aspect which we are very much aware  
13 of is on the local hospital management protecting the  
14 autonomy of hospital boards. We feel very strongly on  
15 this.

16 We also feel on the second one, number  
17 five, the integration of hospital construction programmes,  
18 it is very essential that in the planning and construc-  
19 tion of hospitals that it be done a regional basis.  
20 This is to prevent unnecessary small hospitals being  
21 built where maybe a regional hospital would be sufficient.  
22 This is a definite saving of money to the taxpayer and  
23 also to a more efficient hospital programme.

24 There is one subject that we bring out  
25 which has a tremendous impact to the patient and that is  
26 our hospital labour negotiations. The general public  
27 may not be aware of this, but seventy-two per cent of  
28 the cost of hospital operations is personnel. The  
29 personnel of hospitals have more and more unionized  
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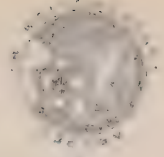


1 professional associations and the impact on the cost of  
2 hospitals is being very serious. This must be dealt with  
3 by all hospitals.

4 We feel very strongly on the co-  
5 operation amongst hospitals. This, of course, as we  
6 are here as the association of hospitals which must be  
7 protected; I will briefly say that this can come about  
8 with the government of the country fully supporting any  
9 costs of the hospital in their operating rate. The  
10 association's, their main objective is education and we  
11 do hope that the Dominion Government will fully support  
12 this in the future.

13 We briefly studied the medical care in  
14 hospitals which we all accept as the vital part of the  
15 hospital; the hospital without a medical staff is  
16 completely useless. We wish encouragement and co-  
17 operation between the medical profession and hospital  
18 people.

19 Then there has been a lot done in this  
20 area. I wish to briefly state that something has come  
21 into Canada which started in the United States some years  
22 ago which was briefly called the professional activities  
23 study. This is a study, a complete study of the  
24 professional activities of a medical staff in the  
25 hospital and there is a pilot plan in British Columbia  
26 at the present time of five hospitals. This pilot plan  
27 is, I believe, quite successful. We bring this up to  
28 show the necessary liaison between the hospitals and  
29 the professional staff. There should be studies right  
30 across the country and we do hope that government will



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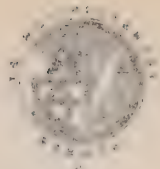
1 recognize this and pay the cost of it and the operating  
2 costs of hospitals.

3                               Very briefly we have two subjects that  
4 are not in our brief that have been brought up at recent  
5 meetings. One of these is on the present position of  
6 the Indian T.B. hospitals and their future. The use is  
7 declining in the activities of the T.B. hospitals and  
8 we feel rather strongly they could be put to better use.  
9 I would like Mr. Hughes to enlarge on this subject.

10                           MR. HUGHES: I would like to just  
11 briefly touch particularly on the situation in the  
12 province of British Columbia where three sanatoria are  
13 in existence operated by the Indian Health Service, one  
14 at Chilliwack, one at Prince Rupert and another at  
15 Nanaimo. As the incidence of T.B. gradually declines  
16 we believe it declines amongst Indians as it has declined  
17 among other people in Canada and there seems to be  
18 some tendency for the present T.B. sanatoria to engage  
19 the services of medical specialists in other fields and,  
20 shall I say, to go into the general acute care hospital  
21 practice rather than just operating as they were  
22 originally set up as T.B. sanatoria.

23                           THE CHAIRMAN: Are these provincially  
24 operated institutions or federal?

25                           MR. HUGHES: They are federal. The  
26 situation, as we see it, is that this is somewhat of a  
27 hazard and may throw the acute care hospital position  
28 out of balance if this condition obtains in other parts  
29 of Canada. We know the situation in British Columbia  
30 and have reason to think it may obtain in other parts of



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1 Canada and it may throw our acute care hospital out of  
2 balance if it continues that a T.B. sanatorium becomes  
3 an acute care hospital rather than what it was originally  
4 set up to do. It is our feeling that the Indian Hospital  
5 is the place to handle the acutely ill Indian population  
6 as it does other people who are resident in Canada, and  
7 we submit this to the Commission as something that may  
8 be studied further and on which we are prepared to make  
9 an additional written submission. As our president has  
10 stated, we have studied this particular one so recently  
11 it is not included in the brief but we are prepared to  
12 make a written statement on it.

13 THE CHAIRMAN: If you would make a  
14 written submission in due course we would be pleased to  
15 have it. I do not know of any other T.B. Indian  
16 sanatoria in Canada outside of British Columbia.

17 MR. HUGHES: We will check that and  
18 cover it in our brief.

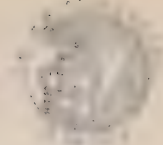
19 THE CHAIRMAN: There may be some in  
20 the northern territories on the border-line along Alberta  
21 and Saskatchewan.

22 MR. SLADE: I am sorry, I think I  
23 should have introduced my group.

24 Mr. Jim Hughes has just spoken and he  
25 is our vice-president. Sister Loretto is the administra-  
26 tor of St. Vincent's Hospital and president of the  
27 Catholic Hospital Association. Mr. Kenneth Conibear is  
28 executive-secretary of the Association.

29 There is one quite vital thing we would  
30 wish to bring up and that is construction grants. The





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1 federal government at the present time have acute  
2 hospitals grant of \$2,000.00 per bed. Very roughly,  
3 this is something between ten per cent and twelve per  
4 cent of hospital construction costs in British Columbia.  
5 There are many organizations, religious organizations  
6 and communities who have very little power to raise  
7 money and our Association feels quite strongly that the  
8 federal government grants are insufficient to provide  
9 adequate hospital construction in the province.

10 THE CHAIRMAN: What does the provincial  
11 government contribute?

12 MR. SLADE: Fifty per cent.

13 THE CHAIRMAN: Plus \$2,000.00?

14 MR. SLADE: Plus \$2,000.00 per bed.

15 THE CHAIRMAN: Which works out at  
16 what? About sixty-five per cent?

17 MR. SLADE: Very roughly that. There  
18 are different grants, of course, as you are aware.

19 THE CHAIRMAN: That \$2,000.00 per  
20 bed, it is on new beds?

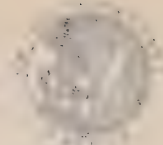
21 MR. SLADE: Yes, new beds.

22 THE CHAIRMAN: But there are other  
23 factors that enter into it?

24 MR. SLADE: Yes, there are renovations  
25 where both governments grant one-third each towards the  
26 cost of renovations.

27 THE CHAIRMAN: I was trying to figure  
28 out what the percentage, the total would be on a  
29 combined figure?

30 MR. SLADE: It varies, of course, with



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1 the actual cost of the hospital. In other words, the  
2 provincial government will pay fifty per cent regardless  
3 of cost; if the hospital costs \$10,000.00 or \$20,000.00  
4 a bed they pay fifty per cent but the federal government  
5 is limited to the \$2,000.00 per bed regardless of the  
6 type of hospital building.

7 THE CHAIRMAN: You record your unit  
8 costs at \$20,000.00 a bed?

9 MR. SLADE: I am not prepared to say  
10 at the present time because it varies so much,  
11 community hospitals, large centres.

12 THE CHAIRMAN: I am talking about one  
13 of the larger hospitals, three hundred and fifty beds.

14 MR. SLADE: Close to \$20,000.00.

15 THE CHAIRMAN: And, of course, where  
16 it is a municipal hospital where there is a tax base,  
17 the money comes from the local taxpayer; if it is a  
18 voluntary hospital the money has to come from the  
19 institutions, the organization that proposes to build  
20 the hospital.

21 MR. HUGHES: This is possibly  
22 accented in a city such as our own where we have one  
23 large very efficient and very well run hospital which is  
24 supported by municipal tax base, but the other hospitals  
25 in Vancouver are not run by municipal funds in any way.

26 THE CHAIRMAN: Do you want to add  
27 any more about construction grants, Mr. Slade?

28 MR. SLADE: There is one thing we do  
29 feel quite strongly about; I think all governments and  
30 all the public are fully aware of the necessity of the



the actual cost of the hospital. In other words, the  
of cost; if the hospital costs \$10,000.00 or \$20,000.00  
a bed they pay fifty per cent out the Federal Government  
is limited to the \$2,000.00 per bed regardless of the  
type of hospital building.

THE CHAIRMAN: You record your unit  
costs at \$20,000.00 a bed?  
MR. SLADE: I am not prepared to say  
at the present time because it varies so much  
community hospitals, large centres.

THE CHAIRMAN: I am talking about one  
of the larger hospitals, three hundred and fifty beds.  
MR. SLADE: Close to \$20,000.00.

THE CHAIRMAN: And, of course, where  
it is a municipal hospital where there is a tax base,  
the money comes from the local taxpayer; if it is a  
voluntary hospital the money has to come from the  
institution, the organization that proposes to build  
the hospital.

MR. HUGHES: This is possibly  
accepted in a city such as our own where we have one  
large very efficient and very well run hospital which is  
supported by municipal tax base, but the other hospitals  
in Vancouver are not run by municipal funds in any way.

THE CHAIRMAN: Do you want to add  
any more about construction grants, Mr. Slade?  
MR. SLADE: There is one thing we do  
feel quite strongly about; I think all governments and  
all the public are fully aware of the necessity of the



1 whole general programme from the acute, rehabilitatives,  
2 custodial, all the way through the line, and governments  
3 are imploring communities to supply these facilities.  
4 At the present time we know there are many names for  
5 all these different types of care, but we use the name  
6 "nursing homes" where usually a patient is in and  
7 requires bed rest, no intensive medical care, no  
8 intensive nursing care. These are very necessary insti-  
9 tutions to clear the acute beds. The federal government  
10 does not give any grants towards this type of institution.  
11 The provincial government in our province gives a one-  
12 third grant and are trying to encourage communities to  
13 build this type of home to clear the acute beds. We  
14 strongly believe if the federal government would give a  
15 grant of one-third it would encourage this type of  
16 construction and cut down the cost of the acute plan.

17 THE CHAIRMAN: If we move from the  
18 construction phase into the operating phase of the  
19 hospital; British Columbia participates in the  
20 Dominion-provincial programme of sharing operating costs  
21 defined, certain defined operating costs. How has that  
22 system worked out in British Columbia?

23 MR. SLADE: To a great degree but I,  
24 well, I have a fair knowledge across the Dominion because  
25 I sit on the Canadian Hospitals Association Board of  
26 Directors and I have a good knowledge. On the whole we  
27 do have our differences, but on the whole the provincial  
28 plan in British Columbia is very acceptable to the  
29 hospitals.

30 THE CHAIRMAN: How do you operate on





whole general programme from the acute, rehabilitative, custodial, all the way through the line, and Governments are implementing communities to supply these facilities. At the present time we know there are many names for all these different types of care, but we use the name "nursing homes" where usually a patient is in and requires bed rest, no intensive medical care, no intensive nursing care. These are very necessary institutions to clear the acute beds. The federal government does not have any grants towards this type of institution. The provincial government in our province gives a one-third grant and are trying to encourage communities to build this type of home to clear the acute beds. We strongly believe if the federal government would give a grant of one-third it would encourage this type of construction and cut down the cost of the acute plan.

THE CHAIRMAN: If we move from the construction phase into the operating phase of the hospital; British Columbia participated in the Dominion-provincial programme of sharing operating costs defined, certain defined operating costs. How has that system worked out in British Columbia?

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THE CHAIRMAN: How do you operate on



1 an annual budget submitted in advance?

2 MR. SLADE: Yes, all hospitals prepare  
3 their annual budgets and it is presented to the British  
4 Columbia Hospital Insurance Service and they approve the  
5 budgets and it is up to the hospital to live within  
6 that budget.

7 THE CHAIRMAN: That is, the budget  
8 for 1962 has already been submitted?

9 MR. SLADE: Most of them have been  
10 submitted but some of them have not, but it is just a  
11 question of time.

12 COMMISSIONER McCUTCHEON: Do you have  
13 to live within a dollar budget or within a daily rate?

14 MR. SLADE: Actually the total budget  
15 presented is divided by your operating days, of course,  
16 and actually the basis it is on is a per diem rate.  
17 There is one thing I think which is very important and  
18 I believe we would like the Commission to understand  
19 this, that the Association has always strongly made  
20 representations which we have made with agreement that  
21 there is no such thing as a comparable hospital. We  
22 are awfully worried about the word "standards"; we are  
23 worried about "formulas". There is no such thing as  
24 a comparable hospital even if you take two two hundred  
25 bed hospitals. We do have excellent results and  
26 conferences where the provincial government admits that  
27 there are not comparable hospitals and the per diem rates  
28 vary geographically, economically. Those come on through  
29 the per diem cost but the cost may vary from place to  
30 place and if the hospital can substantiate this, the

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vary geographically, economically. Those come on through

the per diem cost but the cost may vary from place to

place and if the hospital can substantiate this, the





1 service allows it.

2 THE CHAIRMAN: Now, with the best  
3 budgetary plans you may finish up with a surplus or a  
4 deficit; if you have a deficit what happens then at the  
5 end of the year? At the end of 1962 if there is a  
6 deficit in operating expenses what happens?

7 MR. SLADE: It increases your over-  
8 draft at the bank.

9 THE CHAIRMAN: Eventually you have to  
10 pay. Is there any place to which you have access?

11 MR. SLADE: No.

12 THE CHAIRMAN: Is the budget re-  
13 negotiable, can it be renegotiated at the end of the year  
14 in terms of actual cost?

15 MR. SLADE: Yes, that is quite  
16 correct, Mr. Chairman. The service is quite acceptable  
17 to any hospital having a deficit, having representation.  
18 I would say as a whole if the hospital can substantiate  
19 it the government is likely to advance it.

20 THE CHAIRMAN: Do you find this works  
21 reasonably satisfactorily?

22 MR. SLADE: Reasonably satisfactorily,  
23 but we cannot possibly agree all the time that everything  
24 is satisfactory. We are not agreed that all the services  
25 that we wish to have are there, We realize Rome wasn't  
26 built in a day. We can enlarge many spheres, nursing  
27 services, laboratory services and everything else.

28 THE CHAIRMAN: You do that at the  
29 beginning of the year when you submit your budget? At  
30 the end of the year you have a deficit because of some



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the end of the year you have a deficit because of some



1 change in the conditions throughout the year, something  
2 like that, you say you are able to go and re-negotiate  
3 and attempt to get that deficit taken care of by the  
4 plan?

5 MR. SLADE: Yes, sir, if it is  
6 substantiated, increasing patient days, if you can show  
7 there was an increase in service requiring more nurses.

8 THE CHAIRMAN: They will adjust it?

9 MR. HUGHES: I was going to say, we  
10 should make it clear to the members of the Commission  
11 and yourself that the B.C. Hospital Insurance Service  
12 does not necessarily accept the budget as it is submitted.

13 THE CHAIRMAN: Once it is agreed  
14 upon?

15 MR. HUGHES: Yes.

16 THE CHAIRMAN: Supposing instead of  
17 a deficit you made a profit.

18 MR. HUGHES: Oh happy day.

19 THE CHAIRMAN: It happens, I suppose?

20 MR. SLADE: It does happen, Mr.

21 Chairman.

22 THE CHAIRMAN: What becomes of that  
23 profit?

24 MR. SLADE: If the hospital is wise---

25 THE CHAIRMAN: What becomes of it  
26 whether they are wise or not, what becomes of it in terms  
27 of financial statements? Does the government recapture  
28 it in the following year or does it go into the surplus  
29 in the hospital account?

30 MR. SLADE: It goes into the surplus





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THE CHAIRMAN: What becomes of it?

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MR. SLADE: It goes into the surplus



1 account.

2 THE CHAIRMAN: From which deficits  
3 and sundries might be taken care of?

4 MR. SLADE: Right, Mr. Chairman.

5 THE CHAIRMAN: Now then, what about  
6 preferred accommodation, semi-private and private  
7 accommodation for which there is a payment above the  
8 per diem rate, who gets that money?

9 MR. SLADE: Well, that can be answered  
10 very easily. If the hospital is in the black or has  
11 a surplus they will retain forty per cent for their own  
12 use.

13 THE CHAIRMAN: Whether they are in  
14 the black or red, what is the formula? Is there a  
15 formula?

16 MR. SLADE: Forty per cent.

17 THE CHAIRMAN: Forty per cent to the  
18 hospital and sixty per cent to the plan?

19 MR. SLADE: Right.

20 THE CHAIRMAN: Regardless of whether  
21 they are in the red or black it is management money?

22 MR. SLADE: If you are in the red you  
23 have to take the forty per cent towards your deficit.

24 THE CHAIRMAN: Is that part of the  
25 negotiations at the end of the year?

26 MR. SLADE: That is an understood  
27 fact. It is an understood fact the forty per cent for  
28 your room preference belongs to the hospital if they can  
29 operate either in the black or with a surplus. If you  
30 have a deficit you cannot substantiate then you use your

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1 funds.

2 THE CHAIRMAN: I am not talking about  
3 a deficit, I am thinking about a deficit you can sub-  
4 stantiate. You have a deficit you can substantiate,  
5 are you saying you must use that forty per cent?

6 MR. SLADE: No. If you can substan-  
7 tiate the deficit then you retain your forty per cent.

8 THE CHAIRMAN: Very well, I understand  
9 you. If it is something that you have spent that isn't  
10 approved you pay it from your pocket?

11 MR. SLADE: Correct.

12 THE CHAIRMAN: If you have a balanced  
13 budget or better this forty per cent belongs to the  
14 hospital to do with whatever management may want to do  
15 with it?

16 MR. SLADE: That is right.

17 THE CHAIRMAN: To be assessed for  
18 future capital expansion or that kind of thing. What  
19 about the dollar a day? You collect a dollar a day from  
20 patients.

21 MR. SLADE: Yes.

22 THE CHAIRMAN: That is collected --  
23 when it is collected I suppose it is credited to the  
24 plan?

25 MR. SLADE: Yes.

26 THE CHAIRMAN: Is that the fact?

27 MR. SLADE: That is correct.

28 THE CHAIRMAN: Supposing it is not  
29 collected, is there a difference here? Is it credited  
30 to the plan when collected or a bookkeeping credit on



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THE CHAIRMAN: Is that the last?

MR. SLADE: That is correct.

THE CHAIRMAN: Supposing it is not

collected, is there a difference here? Is it credited

to the plan when collected or a bookkeeping credit on



1 the day the patient comes in?

2 MR. SLADE: It is credited when  
3 collected. If it is uncollected, in other words, it is  
4 a bad debt and the bad debt is substantiated, then it is  
5 entered in the operating costs. In other words, all bad  
6 debts are covered.

7 THE CHAIRMAN: Are absorbed in  
8 operating costs?

9 MR. SLADE: Right.

10 THE CHAIRMAN: In the current year  
11 or at what period?

12 MR. SLADE: In the current year or,  
13 actually, the adjustments are made in the following year  
14 back. It doesn't really make too much difference.

15 THE CHAIRMAN: These are continuous  
16 adjustments?

17 MR. SLADE: That is right.

18 THE CHAIRMAN: What is the feeling  
19 about this co-insurance? Does your Association support  
20 the idea of co-insurance?

21 MR. SLADE: Oh, I think I can safely  
22 say our Association does support co-insurance.  
23 Originally, I suppose it is a deterrent, whether a big  
24 enough deterrent is a matter of opinion.

25 THE CHAIRMAN: How much bookkeeping  
26 is involved in it?

27 MR. SLADE: Practically nothing, Mr.  
28 Chairman. It is routine, very easily collected.

29 THE CHAIRMAN: You find the public --  
30 it is quite acceptable?





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1 MR. SLADE: We have had no objections.

2 THE CHAIRMAN: To the patient?

3 MR. SLADE: We have had no objections.

4 It is very easily collected money. The bad debts on co-  
5 insurance are very, very minimum.

6 THE CHAIRMAN: In the matter of  
7 utilization of hospital accommodation, you referred to  
8 the other type of accommodation which if it was avail-  
9 able would facilitate patients leaving acute hospitals  
10 and so forth, but apart from that have you any observa-  
11 tions to make on utilization in terms of longer stay,  
12 longer patient stay than elsewhere because of any  
13 factors that are attributable to British Columbia?

14 MR. SLADE: Would you suggest, Mr.  
15 Chairman, we consider a comparison of length of stay  
16 in British Columbia and the State of Washington?

17 THE CHAIRMAN: No, I am just wonder-  
18 ing about the matter of utilization. For instance, the  
19 plan doesn't cover your out-patient department. I think  
20 you recommend that it should.

21 MR. SLADE: We have definite opinions  
22 on that, Mr. Chairman.

23 THE CHAIRMAN: If the out-patient  
24 was covered by the plan, what is your view as to whether  
25 that would affect the length of stay, the utilization  
26 of the hospital for diagnostic purposes, perhaps,  
27 unnecessarily?

28 MR. SLADE: Yes, we do feel that a  
29 plan brought out with a great degree of care -- I would  
30 like to mention at this time, Mr. Chairman, that the



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1 expansion of diagnostic plans will depend upon facilities.  
2 We are very much aware of that. There have been studies  
3 made, and we have taken our own studies, we are rather  
4 doubtful at the present time that a sudden -- to bring  
5 a diagnostic plan in, we are very doubtful whether there  
6 is enough actual physical facilities or enough technical  
7 facilities. There is a very serious shortage of  
8 technical staff in these fields.

9 THE CHAIRMAN: That is in your  
10 hospitals?

11 MR. SLADE: Yes.

12 THE CHAIRMAN: Supposing the  
13 diagnostic costs and so forth were paid outside the  
14 hospital in the doctor's office, do you think that would  
15 lessen the admissions in acute hospitals?

16 MR. SLADE: In other words, Mr.  
17 Chairman, regardless of where diagnostic service was  
18 given, whether it was in the hospitals service or in the  
19 doctor's office, would it affect the length of stay?

20 THE CHAIRMAN: Utilization.

21 MR. SLADE: We definitely believe  
22 that many people, if they could get assistance or  
23 diagnostic services paid the use of the hospital service  
24 would be lessened.

25 THE CHAIRMAN: Is it a fact that your  
26 hospitalization is paid and if you get into the hospital  
27 you will get diagnostic service there?

28 MR. SLADE: Right.

29 THE CHAIRMAN: If you stay out of  
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1 MR. SLADE: Yes.

2 THE CHAIRMAN: So it is an inducement  
3 to go to the hospital?

4 MR. SLADE: A patient could pay \$40.00  
5 for diagnostic services which would cost them \$2.00 for  
6 a stay of two days in the hospital.

7 THE CHAIRMAN: Any questions, Dr.  
8 Baltzan?

9 COMMISSIONER BALTZAN: Not much in the  
10 way of questions, Mr. Slade, Sister and gentlemen. I  
11 take it your paragraph 13 to 24 -- I take it that this was  
12 you plea to avoid the rubbing off, I am not being  
13 facecious, of human features from the coin of the realm.

14 MR. SLADE: Yes.

15 COMMISSIONER BALTZAN: I am being  
16 somewhat poetic. You don't wish to see this replaced by  
17 inanimate formula?

18 MR. SLADE: Right.

19 COMMISSIONER BALTZAN: It is a good  
20 reminder when we are always talking about dollars and  
21 cents. You have said that seventy-two per cent of the  
22 operating costs are due to personnel costs. Would you  
23 explain that? Is that wages? What do you mean by that?

24 MR. SLADE: Wages and salaries.

25 COMMISSIONER BALTZAN: Wages and --?

26 MR. SLADE: Wages and salaries, total  
27 payroll, in other words for every one hundred dollars  
28 it costs seventy-two dollars in payroll alone.

29 COMMISSIONER BALTZAN: In other words,  
30 when we say today the cost of hospital services are going





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MR. BLADE: Wages and salaries, total

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When we say today the cost of hospital services are going



1 up day by day, nearly three-quarters of that is the cost  
2 of maintaining the personnel?

3 MR. SLADE: Maintaining of personnel  
4 and increasing wages, but there are other factors, of  
5 course. The trend, the medical trends in hospitals,  
6 especially in the field of nursing is requiring more and  
7 more personnel to carry out the very difficult procedures.

8 COMMISSIONER BALTZAN: So it also  
9 includes quantity?

10 MR. SLADE: Quantity.

11 COMMISSIONER BALTZAN: Increased  
12 quantity raises your percentage of cost.

13 MR. SLADE: Right.

14 COMMISSIONER BALTZAN: Thank you very  
15 much.

16 THE CHAIRMAN: Dr. Van Wart?

17 COMMISSIONER VAN WART: In number 31  
18 in your exhibit 3 you state in the second paragraph of  
19 eighty-seven public hospitals in the province, forty-  
20 eight are legally bound to negotiate with the Registered  
21 Nurses' Association of B.C. for annual contracts involving  
22 the nursing staff. How long has that been in existence?

23 MR. SLADE: I cannot answer too  
24 specifically, but the registered nurses of Alberta actually  
25 came under the jurisdiction, as a certified union under  
26 the Labour Act, it would go back eight years. This has  
27 greatly increased each year and each year there are more  
28 of the groups certified all the time.

29 COMMISSIONER VAN WART: You mentioned  
30 you were on the Canadian Hospital Association Executive.



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and increasing wages, but there are other factors, of  
course. The trend, the medical trends in hospitals,  
especially in the field of nursing is requiring more and  
more personnel to carry out the very difficult procedures.  
COMMISSIONER BATTMAN: So it also  
includes quantity?  
MR. SLADE: Quantity.  
MR. SLADE: Right.  
COMMISSIONER BATTMAN: Thank you very  
much.  
THE CHAIRMAN: Mr. Van Wart?  
COMMISSIONER VAN WART: In answer to  
in your exhibit 3 you state in the second paragraph of  
eighty-seven public hospitals in the province, twenty-  
eight are legally bound to negotiate with the Registered  
Nurses' Association of B.C. for annual contracts involving  
the nursing staff. How long has that been in existence?  
MR. SLADE: I cannot answer too  
specifically, but the registered nurses of Alberta actually  
came under the jurisdiction, as a certified union under  
the Labour Act, it would go back eight years. This has  
greatly increased each year and each year there are more  
of the groups certified all the time.  
COMMISSIONER VAN WART: You mentioned  
you were on the Canadian Hospital Association Executive.





1 Does such a condition exist in any other province in  
2 Canada?

3 MR. SLADE: There is no -- none of the  
4 nurses in any other province in Canada are certified  
5 under the Labour Act.

6 COMMISSIONER VAN WART: Thank you.  
7 Turning to number 43 and 45, it is our conviction that  
8 governments should have absolutely no part, that is, in  
9 the negotiations. Would you elaborate a little bit on  
10 your reasons? You go on to mention that freedom of  
11 action at the local level, you think, is desirable, and  
12 you go on to say that government is paying so much money  
13 in it they are apt to creep into it. You say they  
14 absolutely should not have any authority.

15 MR. SLADE: We feel quite strongly  
16 upon this, Mr. Chairman. I may say I think the government  
17 believes in it also. The government, the provincial  
18 governments are responsible with the aid of federal grants  
19 to pay operating costs of hospitals. Of course, they  
20 must work with the hospitals to make sure the dollar is  
21 justly spent in the interests of the taxpayer. The  
22 employees of the hospital say they are employees of the  
23 hospital, employees of the board. The hospital is not  
24 owned by the government. There are many features. The  
25 employees look to the local hospital as the employer and  
26 are not civil servants. - If at any time there have been  
27 pressures brought about, and we get into the realm of  
28 politics, where a large group of employees -- if the  
29 hospital boards haven't the freedom of action either  
30 individually or collectively to deal with their employees,



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1 there is a possibility groups of employees will become  
2 the pressure group upon the government. We strongly  
3 feel that is one of the main protections of the autonomy  
4 of the hospital and we think of the end result, we  
5 think of the patients, to protect them the employees  
6 must be answerable to the hospitals themselves. They are  
7 part of the hospital and any labour negotiations must be  
8 with the hospital and the government must stay apart  
9 and trust to the hospitals to do their best and honour  
10 any agreement brought about with the hospital and the  
11 employees.

12 COMMISSIONER VAN WART: Thank you.  
13 Sections 47, 48 and 49, you quite clearly state your  
14 position and I don't think there is any question on this.  
15 Thank you.

16 COMMISSIONER STRACHAN: Mr. Slade,  
17 may your budget arrangements be changed by your labour  
18 negotiations?

19 MR. SLADE: If a hospital or hospitals  
20 presented a budget in November of the year 1961 for 1962's  
21 operations and the agreement expired in June of 1962,  
22 the hospital would be actually expected to live in the  
23 1962 budget even if they gave an increase of four or  
24 three per cent to the employees. Actually, in most cases  
25 the government has advanced money to relieve the hospital  
26 of any financial embarrassment.

27 THE CHAIRMAN: Thank you very much,  
28 Mr. Slade, and Sister Loretto and gentlemen. It has been  
29 very helpful and we are grateful to you for having taken  
30 the trouble to give us your opinions which are very





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very helpful and we are grateful to you for having taken  
the trouble to give us your opinions which are very



1 important to us.

2 MR. SLADE: Thank you, Mr. Chairman.

3 THE CHAIRMAN: The Vancouver General  
4 Hospital.

5 THE SECRETARY: Exhibit 163, sir.

7 EXHIBIT NO. 163: Submission of the  
8 Vancouver General  
9 Hospital.

10 SUBMISSION

11 of the

12 VANCOUVER GENERAL HOSPITAL

13 APPEARANCES:

14 Dr. L. E. Ranta

15 Mr. F. W. G. Ruddick

17 DR. RANTA: Mr. Chairman, members of  
18 the Commission, I regret very much that Mr. Hickernell,  
19 our executive director was unable to come to meet with  
20 the Commission today. I have with me Mr. George Ruddick,  
21 who is associate director of the hospital. I am Dr.  
22 Ranta, associate director, medical, of the hospital.  
23 We will attempt to do our best to supply any information  
24 in addition to what appears in our written words here.

25 THE CHAIRMAN: I must say initially  
26 that we are very grateful to the management of the  
27 Vancouver General Hospital for having accepted our  
28 invitation to provide us with the information that is  
29 contained in the document which we received on arrival  
30 here in Vancouver on Monday night. I must say you appear



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THE CHAIRMAN: The Vancouver General

THE SECRETARY: Exhibit 103, sir.

Vancouver General

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1 to have gone to a great deal of trouble, certainly, no  
2 end of trouble, and given us the information that we  
3 asked for and a great deal more useful information.  
4 We want to convey to Mr. Hickernell the thanks of the  
5 Commission for his part in the preparation of this report.  
6 I know, of course, that you gentlemen also did a great  
7 deal, perhaps, in connection with it. Are there any  
8 items that you would like to refer to specifically, Dr.  
9 Ranta?

10 DR. RANTA: Initially I might comment  
11 on the way in which we attempted to bring this report  
12 together, answering the questions contained in your  
13 letter as best we could. We regret, very much, it was  
14 only on your arrival that you received this report. This  
15 was a combination of factors over which we felt we didn't  
16 have any control.

17 THE CHAIRMAN: There was no implied  
18 criticism, because when I saw it I was surprised that you  
19 were able to do as much in the time that we had allowed  
20 you after I wrote you in November.

21 DR. RANTA: Thank you very much, sir.

22 What we tried to do is to bring this  
23 forward as much as possible and consequently it does  
24 contain what we are able to pull together on our 1961  
25 statistics so that when the Commission wants to examine  
26 into this it won't be all statistics of two or three  
27 years, because we realized this always takes time to  
28 absorb material of this type.

29 THE CHAIRMAN: The information here  
30 will come not only to the Commission initially, but it



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will come not only to the Commission initially, but it



1 will go to our research staff and that is where it will  
2 do a great deal of good, and be very valuable to them.

3 DR. RANTA: Yes. Well, the way in  
4 which we approached this was to present to you in the  
5 first sections the basic raw statistics of the number  
6 of beds that we have, which now stand at 1563 active  
7 beds, of which we have a normal population in the  
8 hospital of somewhere a little over fourteen hundred  
9 patients at any one time, with an average length of stay  
10 at the present time of somewhere around 13.7 days.

11 This has been a figure that has not changed very much.  
12 We presented this information in order to demonstrate  
13 the gradual evolution over the past five years of the  
14 services within the hospital.

15 We also tried to demonstrate the effect of  
16 this pressure of a very high occupancy rate which has  
17 been up over ninety-five per cent and is still running  
18 nearly ninety-two per cent, and the rate at the moment  
19 is running at ninety-five per cent again; that, what  
20 impact this has had on the actual utilization of services  
21 within the hospital, and we took a view of the services  
22 that easily come to mind such as laboratory services,  
23 and the very large increase that modern science has  
24 brought upon us in terms of laboratory services, out of  
25 keeping, as a matter of fact, with the increase in the  
26 number of beds or the increase in the number of patients.

27 Then, also, we have attempted to  
28 demonstrate that these tests were much more elaborate  
29 and complex than they used to be, even as short a time  
30 ago as five years. We also carried out the same





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DR. KANTHA: Yes, well, the way in  
which we approached this was to present to you in the  
first section the basic raw statistics of the number  
of beds that we have, which now stand at 1563 active  
beds, of which we have a normal population in the  
hospital of somewhere a little over fourteen hundred  
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at the present time of somewhere around 12.7 days.  
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ago as five years. We also carried out the same



1 procedure as far as dealing with radiological services,  
2 and then turning over to the question of the utilization  
3 of beds, we presented to you the information that you  
4 have requested with respect to the high utilization of  
5 certain services and the over-utilization of others,  
6 and in our particular circumstances with proposed  
7 mechanization within the community our orthopaedic  
8 services are very heavily used. Our urological services  
9 are very heavily used, because, perhaps, we are blessed  
10 with more people in the over sixty-five age group in  
11 British Columbia and Vancouver than in most areas of  
12 Canada, and in certain other areas our utilization is  
13 perhaps much less than it has been in former years.  
14 For example, our maternity services are not as heavily  
15 used as they were a few years ago. Our ophthalmological  
16 services are perhaps not as heavily used, but this is  
17 a point that my ophthalmologist friends might debate  
18 a little because they deal more outside of the hospital  
19 than within the hospitals.

20 We did go on to provide information  
21 which you do not ask for, but we thought might be of use,  
22 and I would like to explain why we presented it. We  
23 felt it might be of value to the Commission to sense  
24 the impact that past community pressures have placed  
25 upon one hospital in the community, and this has been  
26 reacted to by the development of services, by the  
27 introduction of new services, by the expansion of certain  
28 services, and we illustrate these in a number of  
29 situations. I think one of them particularly which has  
30 an impact on many sections of the hospital is the



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1 development of our cardiac surgical programme which in  
2 1958 had four -- we did four cases. In 1961, there  
3 are one hundred and twenty-seven cases. And the growth  
4 of these very, very time-consuming cases plus the  
5 pressures that they have on laboratories, ranging all  
6 the way from laboratory to laundry, that this is merely  
7 illustrative of the community pressures that develop  
8 with the growth of science, the growth of medical  
9 sciences as well as the improvement in the medical  
10 services that are offered within the community.

11 Then, we felt it would be of value to  
12 the Commission to make some comment about the pressures  
13 that now exist upon the hospital. We prepared a section  
14 dealing with the plans that have been approved by our  
15 board of trustees of the future developments that would  
16 take place and, again, as we are administrative people  
17 this is not as much our concern but the board of trustees  
18 concern, again, provided the board of trustees are able  
19 to find the money both for capital costs and operating  
20 costs.

21 We have indicated here, I think, as  
22 seemed to be suggested in your letter, an interest in  
23 possibly the impact of the difficulty of getting certain  
24 types of patients within hospitals because long term  
25 facilities are not available. You will note that we  
26 have had plans and have made studies with respect to  
27 home care programmes which unfortunately to date we have  
28 not been able to get financed.

29 We are in the process now of studying  
30 the possibility of establishing, along with the modern



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1 concepts of the care of chronic patients, a section of  
2 the hospital which would be newly built for the recep-  
3 tion of active chronic cases in order to serve as an  
4 intermediary rehabilitation stage before they go on to  
5 other rehabilitation fields in the community.

6 This has been the general tenor and  
7 intent of our presentation. We have not gone into, as  
8 you did not ask for it -- we have not gone into financing  
9 problems and we would really not be prepared to answer  
10 questions on that. Although, as the chairman of our  
11 board of trustees wrote in his letter to you, if there  
12 is any additional data you would like to have, at least  
13 the way he told it to me, that I was to convey to you  
14 all you need to do is ask and the material will be  
15 gathered together for you.

16 THE CHAIRMAN: Yes. And that is the  
17 manner in which the submission will be dealt with. It  
18 will be reviewed by our research director, because there  
19 is no doubt that from the information you have furnished  
20 it will probably open up other avenues to him which he  
21 will think should be explored, and he will communicate  
22 directly with the hospital.

23 DR. RANTA: Very good, sir. Thanks,  
24 sir.

25 COMMISSIONER BALTZAN: Dr. Ranta,  
26 would you turn please to page 4. I find this page  
27 extremely interesting. Your day occupancy has not  
28 changed from 1957 to 1961. That is, if we leave the  
29 fractions out?

30 DR. RANTA: That is right.







1 COMMISSIONER BALTZAN: 13.8 to 13.7?

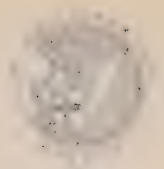
2 DR. RANTA: That is right.

3 COMMISSIONER BALTZAN: That is very  
4 interesting. By the same token, has your turnover of  
5 patients remained about the same?

6 DR. RANTA: Well, we have gradually  
7 increased in the number of patients that we turnover.  
8 On page 6, there is our figure with respect to the  
9 actual number of admissions. You will note that they  
10 have progressively increased from -- this is including  
11 the new part -- from thirty-six thousand a year to  
12 forty-one thousand five hundred. But this has been  
13 attributable principally to the actual increase in the  
14 number of beds.

15 However, I think that there is  
16 additional information on page 5 which we felt might be  
17 of value. For a number of years, we have been using  
18 March, which is one of our busiest months, and I think  
19 for practically every hospital. We have been using that  
20 as the indicator month and we had a very careful  
21 analysis of the length of stay of patients that are  
22 discharged during that month, and we have indicated in  
23 the top table here also the figure for March of 1948,  
24 which was the month of March prior to the introduction  
25 of the hospital insurance programme in British Columbia.

26 You will notice at that time that of  
27 those patients who remained in the hospital less than  
28 thirty days in 1948, the length of stay was 7.9 days.  
29 In 1961, it is nine days, which is a relatively little  
30 change.



COMMISSIONER HALLAM: 11.8 to 12.7?

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1 When one considers the table in 1948,  
2 the length of stay of patients who remained in hospital  
3 thirty days or longer -- the length of stay of 56.7 days.  
4 But in 1961, it was 55.7 days.

5 In other words, it had reduced by one  
6 day, but the figures down below in the next table indicate  
7 that in 1948 there were 4.7 per cent of our patients  
8 stayed thirty days or longer, but now, 9.5 per cent of  
9 our patients. It has actually doubled the number that  
10 stayed thirty days.

11 COMMISSIONER BALTZAN: And your  
12 hospital serves as a general hospital, but it also is  
13 presently functioning as a university hospital?

14 DR. RANTA: Well, we are the principal  
15 teaching hospital, yes.

16 COMMISSIONER BALTZAN: Well, one might  
17 look at that 13.7 figure being a little bit greater than  
18 the national average, but actually you are lower than  
19 most university hospitals?

20 DR. RANTA: Yes.

21 COMMISSIONER BALTZAN: I find in your  
22 second last paragraph a very interesting statement. We  
23 are always looking for a reduction in the number of days.  
24 When the average length of stay is reduced, the level of  
25 service demanded of many departments at the hospital is  
26 increased.

27 In other words, one day less is not so  
28 many dollars less, but actually so many half dollars  
29 more?

30 DR. RANTA: It could very well be, yes.



When one considers the table in 1946,

the length of stay of patients who remained in hospital thirty days or longer -- the length of stay of 56.7 days. But in 1946, it was 75.7 days.

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day, but the figure down below in the next table indicates

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1 because the patient demands more services in the first  
2 few days of admission, and the more patients you admit  
3 the higher the costs are.

4 COMMISSIONER BALTZAN: So, it just  
5 cannot be taken as rule of thumb, because you save a day  
6 you are saving a dollar. We will say it is the other  
7 way about: You are adding to your dollar?

8 DR. RANTA: That is right.

9 COMMISSIONER VAN WART: Dr. Baltzan  
10 has cleared up the problem I had in mind.

11 COMMISSIONER BALTZAN: That is what  
12 you have done for me several times.

13 THE CHAIRMAN: Thank you, again, Dr.  
14 Ranta. As I say we are exceedingly grateful to you and  
15 your associates.

16 COMMISSIONER GIRARD: May I add that  
17 I would like Dr. Ranta to convey to Miss King my  
18 congratulations on the very clear, concise expose of  
19 the problems facing a director of nursing in trying to  
20 staff a hospital today for twenty-four hours.

21 DR. RANTA: I am glad you could see  
22 Miss King's handwriting in the report, even though as  
23 chairman I had the job of pulling it together. I found  
24 that the only thing the chairman really could do was  
25 perhaps an opening paragraph and the statement at the  
26 end.

27 I am not suggesting, however, this is  
28 really what the Chairman of a Commission does, but this  
29 seemed to be the case here.

30 COMMISSIONER GIRARD: I recognize all





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COMMISSIONER BALTMAN: What is what

you have done for me several times.

MR. CHAIRMAN: Thank you, again, Dr.

Ranta. As I say we are exceedingly grateful to you and

COMMISSIONER GIBBARD: May I add that

I would like Dr. Ranta to convey to Miss King my

congratulations on the very clear, concise expose of

the problems facing a director of nursing in trying to

staff a hospital today for twenty-four hours.

MR. RANTA: I am glad you could see

Miss King's handwriting in the report, even though as

that the only thing the chairman really could do was

perhaps an opening statement and the statement at the

I am not suggesting, however, this is

really what the chairman of a commission does, but this

seemed to be the case here.

COMMISSIONER GIBBARD: I recognize all



1 the problems and all the tribulations.

2 THE CHAIRMAN: We will now hear from  
3 the Young Women's Christian Association of Vancouver.

4  
5 --- EXHIBIT NO. 164: Submission of the  
6 Young Women's Christ-  
7 ian Association of  
8 Vancouver.

9 --- EXHIBIT NO. 164A: Report to the Board  
10 of Directors, Vancouver,  
11 from the Housing  
12 Programme Committee  
13 re evidence of an unmet  
14 community need.

15 SUBMISSION  
16 OF THE  
17 YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF VANCOUVER

18 APPEARANCE:

19 DR. BINA NELSON

20 MRS. J. A. C. ANDREWS

21 MISS CLETA M. HERMAN

22 THE CHAIRMAN: Mrs. Andrews?

23 MRS. ANDREWS: I am Mrs. Andrews,  
24 member of the Board of Directors of the Vancouver Y.W.C.A.  
25 and chairman of the Physical and Health Education  
26 Committee. On my left is Miss Cleta M. Herman, executive  
27 director of the Vancouver Y.W.C.A. On my right, is Dr.  
28 Bina Nelson, who is director of the Physical and Health  
29 Education Department of the Y.W.C.A.

30 Mr. Chairman and members of the Commission,  
in presenting to you the brief for the Vancouver







1 Association of the Young Women's Christian Association,  
2 we would like to point out why we have undertaken this  
3 step.

4 At the national convention of the Young  
5 Women's Christian Association of Canada, the following  
6 resolution was passed. This was held last summer.

7 "Be it resolved that the Y.W.C.A. of  
8 Canada:

9 (a) Commends the Prime Minister for  
10 appointing a Royal Commission to inquire  
11 into the health needs of Canadians, and,  
12 (b) Make representations to the Royal  
13 Commission stressing the need for a  
14 comprehensive plan of medical care for  
15 all residents of Canada."

16 The National Y.W.C.A. will, I believe,  
17 be bringing information to you when you are in Toronto.  
18 However, we would like to take this opportunity to  
19 present gaps in needs that are here in the local scene  
20 and that we have become aware of through our association  
21 with the public as a private social welfare agency.

22 In the discussion at the convention on  
23 the resolution I have just referred to, one of the  
24 convention delegates made the following comment:

25 "Our recognition of a need constitutes  
26 a moral obligation to do something about  
27 it as a Christian organization, committed  
28 to work for human welfare and social  
29 justice. We are morally obligated to  
30 take further steps to help put our



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beliefs into actual practice."

We have felt this moral obligation and that explains our presence today.

In the terms of reference of this Commission, you were authorized to report on existing health care facilities, the future needs for health services, and the resources to provide such services.

In our brief we have tried to parallel these three areas of inquiry. We have pointed out the services which we presently offer to promote the health, mental and physical, of the people with whom we work. We have endeavoured to show needs in the field of health care that are not being met, and we have also pointed out recourses that we have which we would be delighted to use when funds are available to meet these needs, if they fall in our area of work.

Our chief aims are to point up gaps and to indicate where we would like to be able to help meet these needs. Incidentally, to this we have made two recommendations.

MRS. ANDREWS:

I. That, whereas presently existing schemes of medical care impose limits and exclusions and whereas the health of numerous people is suffering from insufficient medical care due to cost and inadequacy of services, it is recommended:

1. that a comprehensive plan of medical care be made available to all residents of Canada
2. that as a preventive measure, the cost of an annual protective medical examination be in-



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Our chief aims are to point up gaps

and to indicate where we would like to be able to help

meet these needs. Incidentally, to this we have made

two recommendations.

First, a review:

1. First, whereas presently existing schemes of medical

care impose "limits and exclusions" it is necessary to

realize that numerous people are suffering from in-

sufficient medical care due to cost and inadequacy

of services, it is recommended:

1. That a comprehensive plan of medical care be

made available to all residents of Canada

2. That as a preventive measure, the cost of an

annual protective medical examination be in-



1 cluded in the plan.

2 3. that diagnostic and treatment services be  
3 extended in the area of mental health.

4 I would like to point out that in regard  
5 to the first recommendation, that is, a comprehensive  
6 plan of medical care be made available to all residents  
7 of Canada, we are fully aware that we have not indicated  
8 how or by whom this plan would be set up, administrated  
9 or financed. We realize we are not experts in this area.  
10 We work with people and have become aware of needs that  
11 they have and we feel that some plan of this sort would  
12 be a means by which these needs could be met.

13 The second recommendation that we submit  
14 to you is:

15 II. That, with regard to the recent enactment of Bill  
16 C. 131 by the Canadian Parliament (An Act to Encourage  
17 Fitness and Amateur Sport in Canada), the Vancouver  
18 Y.W.C.A. recommends that monies be made available to  
19 both public and private leisure time agencies, who  
20 have an important role to play in providing opportuni-  
21 ties for as many Canadians as possible to enjoy and  
22 benefit from healthy participation in programs of  
23 fitness, recreational activity and amateur sport.

24 We would like to point out that we have  
25 added a last paragraph that indicates ~~the importance that~~  
26 we ~~attach~~ to public education in this whole field of  
27 health care. I think at this time we would welcome any  
28 questions you may have.

29 THE CHAIRMAN: Do Dr. Nelson or Miss  
30 Herman have anything to add?

3. that diagnostic and treatment services be

I would like to point out that in regard to the final recommendation, that is, a comprehensive plan of medical care be made available to all residents of Canada, we are fully aware that we have not indicated how or by whom this plan would be set up, administered or financed. We realize we are not experts in this area. We work with people and have become aware of needs that they have and we feel that some plan of this sort would be a means by which these needs could be met.

The second recommendation that we submit to you is:

11. That, with regard to the recent enactment of Bill C. 111 by the Canadian Parliament (An Act to Encourage Fitness and Amateur Sport in Canada), the Vancouver Y.W.C.A. recommends that money be made available to both public and private leisure time agencies, who have an important role to play in providing opportunities for as many Canadians as possible to enjoy and benefit from healthy participation in programs of

We would like to point out that we have shown a last page again that indicates the importance that we attach to public education in this whole field of health care. I think at this time we would welcome any questions you may have.

THE CHAIRMAN: Do Dr. Nelson or Miss

members have anything to add?





1 MISS HERMAN: I think only to answer  
2 Mrs. Andrews' statement that our main purpose is to  
3 point out the needs that in an association such as ours  
4 where we have a current membership of some six thousand  
5 members we have become acutely aware of the problems  
6 which these people, even in what is the so-called normal  
7 span of our membership, and these are the concerns which  
8 we felt we wanted to present before this Royal  
9 Commission.

10 THE CHAIRMAN: Dr. Nelson?

11 DR. NELSON: I am more interested  
12 in the second recommendation that has been made.  
13 Through my department I see, during the year, about  
14 three thousand to four thousand people and we have  
15 become aware of the certainties that have been included  
16 in the brief to show that there is need for that partic-  
17 ular physical fitness and health programme that should  
18 be made by the proper agencies, very definitely.

19 THE CHAIRMAN: Now, Mrs. Andrews,  
20 in your recommendation one you have the preamble: "That,  
21 whereas presently existing schemes  
22 of medical care impose limits and  
23 exclusions --"

24 Now, that part I would like to pass by  
25 for the moment:

26 "...and whereas the health of numerous  
27 people is suffering from insufficient  
28 medical care due to cost and inadequacy  
29 of services."

30 Your organization deals with the grass-



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Your organization deals with the grass-



1 roots level, with people?

2 MRS. ANDREWS: That's right.

3 THE CHAIRMAN: Now, what is your  
4 information on this as to the people who are suffering  
5 from insufficient medical care due to cost?

6 MRS. ANDREWS: We did I think include  
7 some of these in the brief and perhaps Miss Herman would  
8 like to speak to this and amplify the material given.

9 MISS HERMAN: May I refer the members  
10 of the Commission to page 6 where you see the people  
11 with whom we have direct contact. We have had concern,  
12 for instance, for the student who is on a low income,  
13 students who are on, for instance, Schedule M and whose  
14 margin is very limited. Many of these girls are in our own  
15 residence, and we are acutely aware when illness strikes  
16 they have no insurance plan and no resources unless we  
17 can call upon the very good nature of doctors who might  
18 see this as part of their public service. We have been  
19 fortunate in this regard to be able to get services at  
20 times of need. We are also aware of the problems that  
21 face both the mentally and physically ill person at the  
22 point of rehabilitation, particularly in a transition  
23 period where they may be unemployable and where the costs  
24 of maintaining a degree of health at a time when they  
25 are also undergoing emotional stress is a matter of  
26 great concern. We have also noted from our own experience  
27 the problem of Indian girls who are not eligible for  
28 Indian Health Service. Many of the girls that we meet  
29 fall into this category and who are still in the  
30 position of becoming productive members of our society.



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like to speak to this and amplify the material given.

MISS NORMAN: May I refer the members

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position of becoming productive members of our society.



1 Then the matter which is, we feel, of  
2 great concern to many citizens of British Columbia and  
3 that is the lack of medical coverage for the employable  
4 unemployed. Again, this is a group which we frequently  
5 meet through our service, through our residence and  
6 through our casework department. The incidence of this,  
7 Mr. Chairman, is one that maybe numerically, from our  
8 own experience, is not significant. I have to see an  
9 incident of ten, twelve, twenty of any of these categories  
10 in a year and you cannot say it is a large number when  
11 you are dealing directly with people and in the business  
12 of providing personal services. We bring these to you  
13 not because we can cite from large statistics, over-  
14 whelming numbers, but on behalf of small groups within  
15 our society who undergo great hardship. Because of this  
16 we feel it is incumbent upon us to bring it to your  
17 attention.

18 THE CHAIRMAN: Thank you very much.

19 MRS. ANDREWS: If I might just add  
20 another example; I think you have this appendix, the  
21 housing programme committee report and in the area of  
22 mental health in there I think you will find some  
23 examples of this sort of case.

24 MISS HERMAN: I think we are partic-  
25 ularly concerned too, in the whole area of the kind of  
26 treatment programmes which can be made available. I  
27 think our concern at the moment is shared by many social  
28 agencies who are seeing the need for the small treatment  
29 centre which is at a great premium at this time. This  
30 comes forcibly to us at the Y.W.C.A. since we have two



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ularly concerned too, in the whole area of the kind of treatment programmes which can be made available. I think our concern at the moment is shared by many social agencies who are seeing the need for the small treatment centre which is at a great premium at this time. This comes obviously to us at the Y.W.C.A. since we have two





1 residences, one at the main building and a small  
2 residence with a capacity of about ten girls and in both  
3 instances a great deal of pressure for us to provide  
4 living accommodation for girls for whom no appropriate  
5 treatment centre is available. We find ourselves then  
6 caught in trying to provide a stop-gap service which we  
7 feel deters the over-all rehabilitation of the individual  
8 involved. We are very concerned in our submission to  
9 which Mrs. Andrews referred, we have pointed out the  
10 incidence that we have ourselves experienced. Again,  
11 numerically we cite ten to twelve cases within a year  
12 for whom we felt we were not in a position to provide  
13 the appropriate residential situation, no further  
14 appropriate residential programme was available, not  
15 because there are not a few but they are working at  
16 capacity with the result of a further breakdown of the  
17 person. We have cited situations that we have followed  
18 up, possibly parties in Oakalla, possibly in other types  
19 of detention that might have been prevented. This is  
20 a matter of great concern to us.

21 COMMISSIONER BALTZAN: Thank you  
22 ladies for your presentation and especially for alerting  
23 us that you are so very much interested in this field.  
24 I have no questions.

25 COMMISSIONER FIRESTONE: Mrs. Andrews,  
26 I would like to refer to one of your recommendations on  
27 your first page, paragraph I, in which you recommend:

28 "That a comprehensive plan of medical  
29 care be made available to all residents  
30 of Canada."



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COMMISSIONER BARTMAN: Thank you

ladies for your presentation and especially for alerting us that you are so very much interested in this field. I have no questions.

I would like to refer to one of your recommendations on your first page, paragraph 1, in which you recommend that a comprehensive plan of medical care be made available to all residents



1 We appreciate your supplementary comments  
2 that for a group like your own it may be difficult to  
3 come forward with proposals as to what kind of programme  
4 and how it can be financed. We appreciate these comments  
5 and respect them. I am just wondering whether I can ask  
6 you a question which would try to obtain from you your  
7 observations that based on your knowledge of this  
8 problem that people in need face, the sort of girls you  
9 deal with. It has been suggested to us that medical care  
10 could be provided for people with low income on the  
11 basis of a means test; now, would you feel that this  
12 would be a desirable system or would you feel that  
13 people with low income should be entitled to medical care  
14 services as a matter of right without having to undergo  
15 a means test?

16 MRS. ANDREWS: I must say I speak from  
17 rather limited experience or discussion of this but in  
18 the Camp study which is also supplementary material,  
19 that committee which I happened to sit on discussed this  
20 in regard to Camp fees for girls. This committee which  
21 here again I cannot say would represent the thinking of  
22 the whole organization, they felt it was not desirable  
23 to have a means test. We know it is done in some places  
24 but we in Vancouver do not approve of it.

25 MISS HERMAN: May I comment, possibly  
26 as a social worker on this point and suggest that the  
27 use of a means test is something that must be used with  
28 some caution. I think that our presentation in general  
29 is considering that there are basic rights to protect  
30 human dignities which are being undermined by our





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1 presentation and that when we point out the comprehensive  
2 nature of all residents, we are conscious of the fact  
3 that many of us ~~through our~~ personal practices have  
4 access to many of the facilities that we are proposing  
5 as a basic right for all citizens. I think in general  
6 we attempt to present the kind of floor to human dignity  
7 which we feel is the right of all citizens. Does that  
8 answer your question?

9 COMMISSIONER FIRESTONE: Would you  
10 say you are in favour or not in favour of a means test?

11 MISS HERMAN: In general I would say  
12 that I am not in favour of a means test if I might speak  
13 personally. It is a subject, however, in speaking for  
14 the Y.W.C.A. that we have not discussed and, therefore,  
15 it must be a personal comment.

16 COMMISSIONER FIRESTONE: Thank you very  
17 much.

18 COMMISSIONER McCUTCHEON: I am not  
19 being critical in saying this but the Y.W.C.A. does  
20 impose a means test on people with whom it deals, does  
21 it not? In other words, you make a determination as to  
22 whether a girl can pay the whole cost of her camping or  
23 you make a determination as to whether she can partici-  
24 pate in a certain programme? I have just glanced through  
25 your literature where she pays part or no part of the  
26 cost.

27 MISS HERMAN: We do not prevent any-  
28 one from receiving any service.

29 COMMISSIONER McCUTCHEON: You do  
30 apply a means test?



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28 COMMISSIONER MCCUTCHON: You do  
29 imply a means test?





1 MRS. ANDREWS: It is a thing she  
2 confesses herself. In the programme booklet it says that  
3 anyone who is not able to pay can see the programme  
4 director and arrangements can be made but she herself  
5 indicates this, we do not inquire into it.

6 MISS HERMAN: In other words, we have  
7 established the kind of floor of saying that she has the  
8 right to have this kind of programme made available to  
9 her and in order to provide this right we recognize in  
10 some instances there needs to be a supplementary contri-  
11 bution made by those who are able to pay. We invite  
12 fees.

13 COMMISSIONER McCUTCHEON: Thank you  
14 very much.

15 COMMISSIONER STRACHAN: Mr. Chairman,  
16 I am sure it is admirable that these ladies should be  
17 interested in the health of these girls and certainly I  
18 am sure we are sympathetic. However, I cannot help but  
19 wonder and I would like to have your expressed opinion  
20 of this, if these girls are always as interested in their  
21 own health as they should be or are they spending monies  
22 for other purposes which might well be spent on health  
23 needs? I refer to such things as excessive hair dressing,  
24 cosmetics, clothes and so on.

25 THE CHAIRMAN: Are they excessive?

26 COMMISSIONER STRACHAN: To some they  
27 may be.

28 MRS. ANDREWS: This is a difficult  
29 question to answer.. I would like to indicate that we are  
30 aware of the need of more education in this field. We

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COMMISSIONER STEVENS: Mr. Chairman,

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interested in the health of these girls and certainly I

am sure we are sympathetic. However, I cannot help but

wonder and I would like to have your expressed opinion

of this, if these girls are always as interested in their

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question to answer. I would like to indicate that we are

aware of the need of more education in this field. We



1 have pointed out in our brief and preamble that ~~with~~  
2 sufficient and effective enough education they might  
3 voluntarily change from the hair-dos to health care.

4 MISS HERMAN: May I add to this that  
5 the Y.W.C.A. as an organization is conscious of this very  
6 question and has tried to play a role in the whole field  
7 of education in health and it is back of this reason that  
8 the Y.W.C.A. requires for certain types of activity a  
9 preventive medical, a general medical. Dr. Nelson can  
10 comment on some of the results of this, if you wish.

11 In doing this as a policy we feel that we are playing our  
12 part in educating the people with whom we come in contact  
13 the importance of keeping in good health and a need that  
14 we see for young women who come to our residence if they  
15 have not obtained from their own family physician we  
16 make a contact with a doctor in order to keep them well.  
17 In our experience in working very closely with the girls  
18 in residence this becomes an extremely important factor  
19 and this we try to interpret to our membership and also  
20 use the knowledge we receive from the medical for the  
21 programme. Perhaps Dr. Nelson would have something ----

22 COMMISSIONER STRACHAN: May I say I  
23 also observe it in the dental health field.

24 MISS HERMAN: We would be interested  
25 if we could go on to explain this and I think one of our  
26 reasons why in our brief we make some reference to the  
27 need of the annual protective medical is because we are  
28 concerned in keeping people in good health, not just in  
29 treating situations.





1 have pointed out in our brief and pressable that with  
 2 sufficient and effective enough education they might  
 3 voluntarily change from the hair-dos to health care.  
 4  
 5 MISS HERMAN: May I add to this that  
 6 the Y.W.C.A. as an organization is conscious of this very  
 7 question and has tried to play a role in the whole field  
 8 of education in health and it is back of this reason that  
 9 the Y.W.C.A. requires for certain types of activity a  
 10 preventive medical, a general medical. Dr. Nelson can  
 11 comment on some of the results of this, if you wish.  
 12 In doing this as a policy we feel that we are playing our  
 13 part in educating the people with whom we come in contact  
 14 the importance of keeping in good health and a need that  
 15 we see for young women who come to our residence if they  
 16 have not obtained from their own family physician we  
 17 make a contact with a doctor in order to keep them well.  
 18 In our experience in working very closely with the girls  
 19 in residence this becomes an extremely important factor  
 20 and this we try to interpret to our membership and also  
 21 use the knowledge we receive from the medical for the

22 COMMISSIONER STACHAN: May I say I

23 also observe it in the dental hospital.  
 24  
 25 MISS HERMAN: We would be interested  
 26 if we could go on to explain this and I think one of our  
 27 reasons why in our brief we make some reference to the  
 28 need of the annual preventive medical is because we are  
 29 concerned in keeping people in good health, not just in



1 THE CHAIRMAN: Have you something to  
2 add, Dr. Nelson?

3 DR. NELSON: I was going to add,  
4 your question whether people themselves are aware of this  
5 need or not, there are quite a number that perhaps  
6 wouldn't be aware. For instance, with this medical  
7 check-up examination that we have, in the month of  
8 January, we have four hundred people in the medical  
9 examination. Out of this fourteen were unaware they  
10 weren't well. They came to us with restricted cards.  
11 In December we have about twelve hundred people for  
12 medical check-up, out of which fifty were unaware that  
13 they were really not suitable to take part in some of  
14 the activities. So, on the part of some people there is  
15 no awareness that they are not really well or physically  
16 fit. We endeavor all the time to make them aware of this  
17 through some means or another.

18 THE CHAIRMAN: Thank you very much,  
19 Dr. Nelson, Mrs. Andrews, Miss Herman. It was very  
20 gracious of you to come and we are very pleased with  
21 your submission.

22 MRS. ANDREWS: Thank you very much.

23 THE CHAIRMAN: We will recess until  
24 tomorrow morning at ten o'clock.

25  
26 --- Whereupon the hearing adjourned.





THE CHAIRMAN: Have you something to

add, Dr. Nelson?

DR. NELSON: I was going to add,

Your question whether people themselves are aware of this need or not, there are quite a number that perhaps wouldn't be aware. For instance, with this medical check-up examination that we have, in the month of January, we have four hundred people in the medical examination. Out of this fourteen were unaware they weren't well. They came to us with restricted orders. In December we have about twelve hundred people for medical check-up, out of which fifty were unaware that they were really not suitable to take part in some of the activities. So, on the part of some people there is no awareness that they are not really well or physically fit. We endeavor all the time to make them aware of this through some means or another.

THE CHAIRMAN: Thank you very much.

It was very

grateful of you to come and we are very pleased with

MRS. ANDERSON: Thank you very much.

THE CHAIRMAN: We will recess until

tomorrow morning at ten o'clock.



















